First Call for Children

"The essential needs of children should be given priority in bad times as well as good" — *Plan of Action, World Summit for Children*

The quality of mercy

UNICEF/Goss/Pic

A health worker from UNICEF Mogadiscio and a Rwandese relief worker together administer oral rehydration salts to a dehydrated baby in the Ndosho camp for unaccompanied children near Goma (Zaire). Somalia, although only slowly emerging from its own years of conflict and ensuing disease, sent a number of volunteers to help in Rwanda's time of need.

Tragedies and crimes come in many varieties in our less than perfect world. Nearly 3 million children die every year simply because they don't receive oral rehydration therapy when they have diarrhoea. Over half a million infants die annually shortly after birth because their mothers were not immunized against tetanus. The figures are stunning, some would say numbing.

Yet, determined people all over continue to mobilize, cajole, push and prod towards a better future for everyone, towards the goals for children and sustainable human development.

In March 1995, governments will gather at the World Summit for Social Development in Copenhagen to give yet another major official impetus to human progress. The world should expect and demand the best from this Summit.

Although crises like Rwanda's can cause some to waver and others to withdraw, there are many, many thousands who continue to find the will, the heart and the resources to help. The forthcoming Summit should buttress their efforts.

We dedicate our centrespread to the people — and especially the children — of Rwanda. And to those who continue to work against what often seem like insurmountable odds for a better world.

We also chronicle several development successes in this issue, including the strong advocacy and mobilization in Somalia that helped counter a cholera epidemic; education initiatives in India, Iraq and Pakistan; and the role the Convention on the Rights of the Child is playing in Romania to keep families together.

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First Call for Children

'The essential needs of children should be given priority in bad times as well as good' — *Plan of Action, World Summit for Children*

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Western hemisphere declared polio-free

UNICEF/Sengupta

In Bangladesh — one of the three countries where 66 per cent of all polio cases occur — a health worker gives an infant the polio vaccine.

By Maanik Mahna

An important child health breakthrough was announced in September when Dr. Carlyle Guerra de Macedo, Director of the Pan American Health Organization (PAHO) and Regional Director for the Americas of the World Health Organization (WHO), declared the Americas a polio-free zone. It is the first region to achieve the designation.

The declaration comes after nine years of collaboration between governments and agencies such as WHO, UNICEF, the United States Agency for International Development, Rotary International, the Inter-American Development Bank and the Canadian Public Health Association. The effort cost over US$500 million, with the countries providing the bulk of the resources themselves.

Certification came after more than three years in which no case of polio was found in the region. The three-year polio-free period signals that indigenous transmission of the polio virus has been interrupted, a requirement for earning the polio-free status set by the International Commission for the Certification of Poliomyelitis Eradication. This is an independent Commission established by PAHO to oversee regional poliomyelitis eradication efforts and to determine when the goal has been achieved.

According to WHO, five other regions are well on their way to becoming polio-free: Western and Central Europe, North Africa, Southern and Eastern Africa, the Middle East and the Western Pacific.

Strong political commitment, collaboration among various agencies and community participation were all keys to the success, according to Dr. Terrel Hill, Senior Adviser on Child Survival in UNICEF. In Peru, where the region's last case of polio was detected, villagers offered the use of their refrigerators to health care workers for storing vaccines. In El Salvador, health officers negotiated cease-fires with guerrilla fighters and the military in order to hold vaccination days. All over, national vaccination days and door-to-door immunization sweeps reached children, with over 20,000 health facilities working to detect polio cases.

UNICEF Executive Director James P. Grant, speaking at the ceremony in Washington, D.C., applauded the hemisphere's elimination of the disease as a milestone towards the global eradication of polio, one of the World Summit for Children goals, stressing the need for continuing immunization and surveillance activities to avoid recurrences.

Globally, the incidence of polio has been on the decline: in 1993, reported cases fell to fewer than 10,000 for the first time. However, WHO estimates the real, largely unreported, case-load was actually 115,000. Two thirds of the world's reported polio cases are currently in Bangladesh, India and Pakistan.

Momentum is building around the world to reach the 1995 goal of eliminating polio in selected countries and the year 2000 global eradication goal. Earlier this year, 400,000 trained health volunteers administered polio drops to over 20 million children in Pakistan. About 100 UNICEF Pakistan staff members participated in the venture.

In Iran, a similar campaign sent over 260,000 health volunteers out to knock on every door of the country's 12 million households. Iran's President vaccinated the first of the more than 8 million children under 5 years of age immunized in the one-day campaign. According to the UNICEF Representative, Mr. Andre Robertfroid, for the first time in Iranian history every family was in contact with a health worker on the same day.

As we approach the World Summit for Social Development (6-12 March 1995), triumphs such as the elimination of polio in the Americas offer concrete lessons and hope. Mr. Grant summarized, "Success in these efforts will not only save and improve millions of young lives, but also give the world leaders who will gather in Copenhagen next March greater confidence in committing their governments to the historic plan that is expected to emerge from the World Summit for Social Development."

Maanik Mahna is a UNICEF consultant.

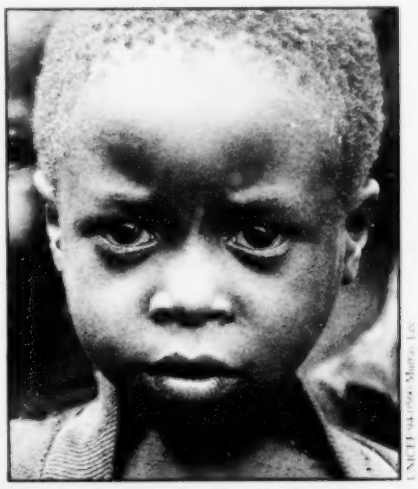
UN Secretary-General appoints expert for 'children in war' study

In June, United Nations Secretary-General Boutros Boutros-Ghali appointed Mrs. Graça Simbine Machel, the former first lady of Mozambique, to undertake a two-year study on the 'Impact of Armed Conflict on Children'.

UNICEF and the Centre for Human Rights will assist in the study. In UNICEF, Dr. Guido Bertolaso, Deputy Executive Director for External Relations, will provide overall support, and Stephen Lewis, Special Adviser to the UNICEF Executive Director, was named Coordinator.

The study will make recommendations for action by the international community in four areas: the relevance and adequacy of existing protection standards; the reinforcement of preventive measures; the protection of children in situations of conflict; and the promotion of their physical and psychological recovery and social reintegration.

The study was first proposed in January 1993 by the Committee on the Rights of the Child, in response to the many catastrophic conflicts affecting the world's children, and was subsequently strongly endorsed by the World Conference on Human Rights meeting in Vienna (June 1993). The United Nations General Assembly then asked the Secretary-General in December 1993 (in resolution 48/157) to appoint an expert.



UNICEF/Holtz Muro

Child at a camp for the displaced in south-west Rwanda. How children can best recover physically and psychologically from war is one focus of the study.

Mrs. Machel's long experience includes work on behalf of more than 250,000 children separated from their families during the period of conflict and destabilization Mozambique underwent in the 1980s.

An Eminent Persons Group, repre-

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How the Convention is changing children's lives

As the Convention on the Rights of the Child is increasingly embraced — 167 countries have ratified the ground-breaking treaty as of 7 October — the international community is focusing on ways of transforming the Convention's protections into concrete realities. Thomas Hammarberg, a member of the Committee on the Rights of the Child, answered questions about the accomplishments and the challenges ahead.

Are the reports submitted by countries to the Committee on the Rights of the Child useful?

The experience so far is that they are very useful, not least for the governments themselves.

I have asked government representatives about their impression of the whole process. Several underlined that the reporting process spurred them to look at the situation of children in a *comprehensive manner*, which has been important in overall budgeting and planning. The mere bringing together of facts about children from various fields has been useful. Crucial discussions have begun on revision of legislation, 'ombudswork' for children and training of personnel.

The reporting guidelines given by the Committee emphasize the importance of four principles — as formulated in the Convention in articles 2, 3, 6 and 12 — of non-discrimination, the best interests of the child, the right to survival and development and, finally, paying attention to the views of the child. One result, for example, is that further stress has been

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Guyana's health service struggles to stay afloat

By Sara Cameron

Health workers may paddle for up to four hours to reach remote clinics in Guyana, where economic decline and structural adjustment have taken a toll on social services.

Through the rich, brown waters of the Pomeroon River glides a dugout canoe carrying six nurses, their uniforms a brilliant white in stark contrast to the dark colours of the rain forest. As the canoe rounds a bend, a jetty appears, at which boats are moored. On the jetty and along the river bank a crowd awaits the arrival of the health post staff.

Muriel Drakes and her assistants have paddled nearly four hours along this river to bring basic health services to patients at the Kabakaburi clinic near a settlement called Charity. Without the clinic, the people — most of them Amerindians — would have to travel for hours by ferry to the hospital in Georgetown.

The clinic's patients suffer from the usual diseases of people who live in remote areas without access to basic sanitation facilities and a safe water supply: diarrhoeal and intestinal infections, respiratory infections, malaria and skin infections. Muriel Drakes weighs the children and records their progress on a growth chart, provides immunizations, advises mothers on good nutrition and diagnoses illnesses. She is not always able to supply the right drugs to treat them, however, because the clinic is inadequately equipped.

"This is a very big problem," she says. "It isn't enough to say to a mother, 'Your child needs antibiotics but you will have to wait for the shipment which we hope will come from Georgetown next week'."

Ailing health service

The problems affecting the small clinic near Charity are typical of those undermining health services throughout Guyana. Older people remember when basic medical care was available to practically everyone. Two decades of neglect and economic decline, however, have left much of the country's infrastructure, including health services, in shambles (*see box*).

Buildings are old and dilapidated, with worn-out examination couches and antiquated weighing scales. There are shortages of properly trained staff, drugs and supplies. Over the last three decades, highly skilled professionals have left the country in droves, leaving behind a skeletal force of dedicated, but frustrated, doctors and nurses like Muriel Drakes.

"Some people have lost their faith in the health service," says Ms. Drakes. "They have been turned away too many times without receiving proper treatment and think it is not worth going to the clinic anymore. We have to change those attitudes but we also have to provide better service."

The decline in use of health clinics in remote areas is particularly evident among pregnant women, who do not visit health posts on a regular basis to monitor the progress of their pregnancy and who frequently give birth without the help of trained attendants. When problems arise, help is sought too late.

Maternal deaths and infant mortality in such areas appear to be much higher than the national average, although funds have not been available to accurately assess the situation. Because people do not consult clinics for advice on modern methods of family planning, pregnancy among young girls and abortions are other causes of maternal deaths.

The will is strong to restore Guyana's health services to their former competence. Crucial to achieving this is giving people the means and knowledge to prevent illness, according to Senior Health Minister Gail Teixeira. UNICEF is backing government efforts by supporting the training of local people as Community Health Workers, providing them with basic equipment and supplies and training in midwifery as well as diarrhoea management, treatment of respiratory diseases and education in basic nutrition.

In particular, the needs of remote areas of the country, such as those around Charity, are given priority in this effort to rebuild Guyana's health service, from its grass roots to its forest canopy.

Sara Cameron is a writer who lives in Barbados.

Economic woes fuel social and health crisis

A 20-year period of economic decline and the structural adjustment programme introduced in 1988 to reverse it have taken their toll on social services in Guyana. As subsidies were removed, prices rose and real incomes fell. In 1990, the World Bank declared Guyana the poorest country in the western hemisphere.

A huge external debt (of almost US$2.1 billion) consumes 70 per cent of government revenues; 70 per cent of the population is estimated to live in poverty, earning less than US$50 per month.

Under-five child mortality, which was around 36 per 1,000 live births in 1965, has risen to 65. The rate of access to safe water is down to 65 per cent, from 77 per cent in 1987, and malaria has been increasing.

Illustration: Christian Clark

Children's Day of Broadcasting reaches growing audience

By AnneMarie Kane

Broadcasters around the world are making plans to celebrate the third International Children's Day of Broadcasting (ICDB) on 11 December.

All Turner Broadcasting networks are actively participating this year and Turner Broadcasting Inc., Latin America, will devote a massive five-hour block to the Day.

Nickelodeon, the United States children's network, is revamping its 11 December programming schedule to present relevant and topical children's programming. Over 100 countries are expected to participate in this international event.

In Scandinavia, Danmarks Radio will carry reports phoned in from different parts of the country by 13 young reporters. President Robert Mugabe of Zimbabwe will answer questions by children in a specially convened press conference.

Other enthusiastic participants are Middle East Broadcasting, Star TV and Monitor Radio (short-wave broadcaster), with a combined audience exceeding 50 million people.

The international broadcasting alliance created by ICDB is truly remarkable, especially as the commercial broadcasting industry refers to the cause as 'non-commercial' and 'non-programmable'.

Tom Johnson, President of Cable News Network, explains the high degree of broadcast support by saying, "We must be constantly alert to the responsibility to report on those who have no constituency, no public relations machine, no power or money to impress us, no sensational, titillating story to attract our attention. This brings me to the cause of children."

Contributions from various international producers have made it possible for UNICEF to offer high-quality, low-cost programming to broadcasters for their use. Choices include hard-hitting documentaries like *Tomorrow We Will Finish* (on child labour in Nepal) and live-action and animated programmes such as Sony's *La Casa Dei Suoni* and Robert Altman's *Video Pen Pals*. In addition, UNICEF has produced *We Speak for Ourselves*, a 15-minute radio programme.

The International Children's Day of Broadcasting has established itself in three short years as one of UNICEF's most successful advocacy initiatives.

In the words of Professor Dieter Stolte, member of the International Council of the National Academy of Television Arts and Sciences, which launched ICDB together with UNICEF, "This particular project has received more enthusiastic support from the International Council than any other outside endeavour in which we have been engaged."

AnneMarie Kane is a media consultant for UNICEF in New York.

Mobilization in an emergency:
How Somalia defeated cholera

Two years ago a brutal civil war and resulting man-made famine killed an estimated 250,000 children in Somalia. Then in February 1994, further disaster struck in the form of cholera. The communications challenge posed by such a public health crisis in ravaged Somalia was extraordinary, the success achieved also extraordinary. CHRISTIAN CLARK reports.

When cholera swept through Somalia in February 1994, it threatened not only lives but also the fragile humanitarian revival in the country.

An estimated 500 people eventually died from cholera, which was first detected in Bossaso, in the country's north-east region, in mid-February. Nearly a month later, when the disease had finally spread to the southernmost port city of Kismayo, some 1,300 kilometres away, the World Health Organization (WHO) declared the outbreak an epidemic. Almost 15,000 cases were confirmed by WHO before cholera was finally brought under control in the major urban areas.

The toll need not have been so great. Still, the quick reaction by the international community, and the mobilization of key groups within a highly stratified and unstable society, kept the toll from being even higher.

Social mobilization in a shattered society

Working with national and international non-governmental organizations, United Nations agencies and concerned Somali health professionals, UNICEF — as the lead agency in the anti-cholera public information campaign — began a social mobilization initiative.

The three basic objectives were to bring together allies to raise awareness for a nationwide anti-cholera effort, to assist in the delivery of resources and services, and to strengthen community participation for sustainability and self-reliance.

Enacting such a programme in a country still reeling from years of war and turmoil was a formidable challenge. Warfare had seemingly shattered any general sense of community in Somalia, along with the foundation on which a community empowerment programme could be based.

Mass rallies or door-to-door information campaigns were extremely difficult to carry out, and there were no sports stars, entertainers, educators or others to lead an advocacy campaign. No established political leaders could give their moral authority, much less provide overall funding, planning or coordination to the effort.

Since the options were limited, all opportunities had to be maximized. The lack of state-sponsored health workers, television stations and a physical infrastructure meant the country's local media had to play a much greater role in programme communication than in other countries.

Similarly, in the absence of functioning government ministries, service clubs and educators, the country's religious leaders, poets and singers were to play a large and important part in social mobilization and alliance building.

Local media expand their role

To enlist the support of the media and educate journalists about the health crisis, UNICEF sponsored a media workshop on cholera in the capital, Mogadiscio, in March. It proved to be a turning point for the anti-cholera campaign.

The workshop, by conferring legitimacy on the local media and appealing to the professionalism of writers, editors and cartoonists, helped underscore the seriousness of the epidemic and the crucial role that the media could play to help.

Participants pledged to file daily reports on the epidemic and provide daily public service messages on cholera. They began a series of joint interviews with top religious leaders and cholera patients, which were later shared with all radio stations covering Somalia, including the BBC Somali service and the UNICEF-supported Radio Voice of Peace in Ethiopia, maximizing their effectiveness.

Due to the country's extremely low literacy rates, radio played a critical role and segments ran frequently, highlighting the danger of cholera and ways to prevent it. Three special round-table radio discussions featuring local Somali health care professionals were broadcast.

To further broaden the campaign in a largely audio culture, the country's popular poets, songwriters and musicians were also mobilized, and they wrote creative and imaginative lines about cholera prevention. While such a ditty as "Cholera, not a love story" might not make it to the top of the music charts, the campaign was effective.

The nation's top political cartoonists were also involved, designing giant (3 by 5 metre) coloured billboards warning of cholera's dangers in the divided capital.

Manoeuvring on the ground

Within days of the outbreak, UNICEF wrote, designed and distributed 550,000 anti-cholera public information leaflets and some 20,000 posters in more than a dozen Somali cities. UNICEF teams working on immunization piggybacked cholera information onto their ongoing door-to-door and loudspeaker campaigns. It became clear, however, that a separate and specific anti-cholera drive, with its own corps of volunteers, was needed.

The question remained how. There was no government with the authority, much less the ability, to coordinate an overall volunteer effort, and volunteerism in Somalia seemed to be all but dead. While limited mobilization of former EPI (expanded programme on immunization) volunteers was achieved in Bossaso and Kismayo, Mogadiscio was where an all-out campaign was needed most.

In the divided capital the few remaining and functioning hospitals were overwhelmed by cholera patients. Too few inhabitants had access to clean, much less running, water. Furthermore, UNICEF water chlorinators were often denied access at gunpoint to areas of the city controlled by competing clan militias. In refugee camps and virtually all areas of the city, sanitary conditions remained generally squalid. Garbage collection in most parts of the country had stopped nearly half a decade earlier.

In the end, with the collaboration of the World Food Programme and the Joint Health Authority (a local political organization made up of health professionals), UNICEF sponsored a food-for-work scheme for 335 social mobilizers and 265 water chlorinators.

The UNICEF messages focused on the handling of food and water, general sanitation and timely referral of patients to a hospital or the nearest health facilities, in a combined loudspeaker and pamphlet distribution campaign in all of Mogadiscio's 15 districts. UNICEF also provided the Joint Health Authority with four vehicles and eight megaphones for public education. During the campaign, UNICEF and partner teams targeted public places in particular, including markets, mosques, schools and water points.

UNICEF was equally successful in getting international as well as local media coverage of the crisis. Cholera was raging at the time American and West European troops were leaving the country. Journalists, bored with the military pomp and ceremony accompanying the troop withdrawal, were taken on tours to cholera hospitals and on missions with UNICEF water-chlorination teams. Newspapers and wire agencies from around the world highlighted the impact of the disease.

In April, more than two months after the outbreak of the disease, another opportunity for mobilizing the public in the anti-cholera campaign arose when leaders of the country's factions signed a peace treaty in Nairobi. Immediate efforts were made to meet with them to try to gain their support for the advocacy campaign. Although similar meetings with top religious leaders had led to the inclusion of anti-cholera messages in sermons during Friday prayers throughout Somalia, proposals for the country's future leaders to hold anti-cholera rallies to increase awareness were sadly not as successful.

What were the lessons learned for the UNICEF team here in Somalia? UNICEF responded to a difficult emergency situation by persuading a number of different groups to fight against a common enemy of children — this time cholera.

Now all the work — the creativity and imagination, dogged perseverance, the adaptation of media strategies to fit the local environment, the mission to mend political fences and deal with those who have the power to affect changes for the children — needs to be followed up. The children of Somalia deserve no less.

Christian Clark is Information Officer, UNICEF Mogadiscio.

Development courses popular in Italy

Courses on development issues are proving popular among students at 22 universities throughout Italy, thanks to the efforts of the Italian Committee for UNICEF. At the University of Rome, for example, more than 750 students enrolled in more than 15 courses offered during the 1993-1994 academic year. The courses cover issues such as North-South relations, cultural diversity, childhood and the environment.

The Italian Committee began promoting multidisciplinary courses on development issues at the university level several years ago. The courses are taught by professors, as well as representatives from research organizations and international and non-governmental organizations.

At the University of Rome, the courses — first offered during the 1990-1991 academic year — have inspired students to initiate their own projects as well. One group of students is helping promote and implement the Convention on the Rights of the Child by conducting a survey on the state of children in Rome.

Students have also created working groups on Africa, Asia, Europe, Latin America and North America which will work with students from those areas on issues affecting childhood.

The initiative was launched by the Italian Committee for UNICEF, which recognized that development studies introduced in junior and high school needed to be continued at the university level, with its fertile environment for research, dialogue, experience and experimentation.

Karin Sham Poo, UNICEF Deputy Executive Director (Operations), led the UNICEF delegation to the European preparatory meeting in Vienna in October for the Fourth World Conference on Women (September 1995). She is pictured here (second left) at a press briefing, with Bilge Ogun-Bassani, Deputy Director, UNICEF Geneva; Stephen Lewis, Special Adviser to the UNICEF Executive Director; and Shalini Dewan, Chief of Editorial, Publications and Photo Section, UNICEF New York.

Group support helps disabled children and their families

By Isabel Mbugua

Three-year-old Mutheu is epileptic and blind, and suffers from cerebral palsy. She cannot sit without support and it is only recently, after home exercises, that she can manage to hold her head up.

Mutheu is one of eight disabled children who have come to Masalani primary school near Kibwezi, some 250 kilometres east of Nairobi, for a monthly play group. There are 15 such play groups in the area, run by parents of disabled children and community health workers.

The groups provide critical support for parents whose children are physically and often emotionally challenged. By sharing their experiences with one another, parents learn practical ways to help their children. Bonding and attachment between parents and children are strengthened as well, in the climate of encouragement and support.

Small miracles

Shaya Asindua, the coordinator of the Community-based Programme for the Rehabilitation of the Disabled, leads the activities.

Outdoor games are encouraged. In one area, some parents use *khangas* (a piece of cloth worn by women as a wrap over their dresses) to swing children back and forth, trying to enhance muscle stimulation.

> ***Children develop strengths ... and learn what others take for granted, such as feeding themselves.***

Activities are chosen to help the children develop strengths and become independent and learn what others take for granted, such as feeding themselves, dressing and washing. Simple exercises — such as blowing bubbles with a straw — stimulate speech development; others improve coordination, movement and balance.

In one corner, a staff member prepares a box into which each child will put his or her name tag.

"This encourages hand and eye coordination," explains Ms. Asindua. "Activities, such as writing, holding objects, sorting out maize from beans or simply picking out bottle tops from a can, increase coordination."

During the session, Ms. Asindua works with individual children and their mothers. These personal meetings help her to assess if a child is ready to be integrated into a regular school.

One child cannot hold herself upright. The social worker makes a note that the mother is not using the special seat that was recommended and tries to find out why. Another mother has been advised to make parallel bars so that her child can use them for support as soon as she learns how to walk. She has not yet made the bars.

Doing enough, doing too much

"When I learned that it was within my power to make her walk like a normal child, I put all my efforts into helping her," said one mother. Her child, Katongu, now an apparently healthy girl of about six, has made great progress. "Today she walks normally. That's something to be proud of," added her mother.

Eighteen-year-old Mwikya, whose mother died when she was young, does almost nothing for herself. She has to be bathed and can hardly wash a cup or her own clothes.

When Mwikya was 12 years old, she gave birth to a child, who subsequently died. No one knows who was responsible and Mwikya herself does not talk about it. Her stepmother says that it was after this that Mwikya developed problems with her legs, making it difficult for her to walk.

Ms. Asindua feels that Mwikya should be encouraged to help with household chores, and to wash her own clothes and bathe herself.

But what is most worrying is the possibility that Mwikya may get pregnant again. "If she does, she will never be able to walk again," says Ms. Asindua. "Her limbs and pelvis cannot support another pregnancy." The social worker takes more notes and arranges to visit Mwikya's home to discuss with the family what needs to be done.

Surveys show that 6 per cent of children under 15 are disabled in Kibwezi, often the result of illnesses such as cerebral malaria, meningitis or fever-related convulsions. Yet, disabilities resulting from these illnesses can often be prevented through early diagnosis and appropriate management and treatment.

Community concern

The programme encourages the placement of disabled children in schools, with about 115 schools participating. For children whose conditions cannot be handled locally or who are so severely disabled that no obvious remedy is available, a social worker visits the home to encourage parents to realize the potential of a child, however disabled.

With the support and commitment of their parents, many children can develop skills that enable them to be self-sufficient members of the community. Disability is, after all, a family and community concern.

Isabel Mbugua is Director of Communications for the African Medical Relief and Emergency Fund in Nairobi.

Somali women's organization breaking new ground

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The war in Somalia has changed society and women's lives, giving them more autonomy and authority. Here a woman in charge of a feeding centre checks staff attendance.

By Aden Mohamed Ali

Women have been the primary victims of violence and social injustice in Somalia. Now, one determined group — Iida Women's Development Organization — is working to make women less vulnerable and to help them attain the rights they have been denied for so long. This is particularly important as Somalia makes the transition from emergency to long-term recovery, which will require the energy and full participation of the entire nation.

Iida, founded in May 1991 by 22 Somali professional women, began working in the area of emergency assistance in 1992. (Iida is a popular woman's name in Somalia.)

"Iida collected data on the displaced population in feeding centres in Mogadiscio and in the towns and villages of Hiran and Lower and Middle Shabelle regions," says Dr. Halima Abdi Arush, chairperson of the organization.

Iida assisted a food distribution project targeted to the needy population in rural and nomadic areas across the country; helped to rehabilitate two elementary schools and the agricultural school near Afgoye town; and assisted in the Mogadiscio city-wide cleaning programme and primary health services.

In April, Iida started a six-month project to train about 100 women in nursing, tailoring, handicrafts and adult computer literacy. UNICEF Somalia has allocated US$30,000 to support the project and contributed a power generator for the Iida Training Centre.

"The project will mark a transition from emergency work to development," says Dr. Arush, who stresses that the integration of Somali women into the reconciliation, reconstruction and redevelopment process of the country is essential.

Iida's primary objectives include educating women; identifying priority needs for women living in urban, rural and nomadic societies; ensuring education and employment opportunities for women; and counselling women who are victims of all forms of violence. The organization also provides training in literacy, health and nutrition, child care, sewing, handicrafts, bookkeeping and marketing, computer training and home economics.

"We advocate for the advancement of Somali women in every forum and hope to work with all women's groups in Somalia," says Dr. Arush.

Aden Mohamed Ali is Assistant Information Officer, UNICEF Somalia.

NEWS BRIEFS

Cambodia: In the largest public health initiative ever conducted on a single day in the country, over a quarter-million children under five years of age received oral polio vaccine during the first of Cambodia's subnational immunization days last February. An estimated 88 per cent of children living in target areas were immunized against polio during the initiative. A second round of immunizations took place in March.

Colombia: Candidates for the vice-presidency of Colombia participated in a forum entitled, 'And What About the Children?' Organized by presidents of the national associations of industry, commerce and agriculture, the forum called on political leaders, businesses, the Government and society in general to meet the goals of the World Summit and to make children a central point of social investment over the next few years. Those present signed a document that will become a National Pact for Children. The vice-presidential candidates presented their positions on problems relating to children and made commitments to achieve health, education and protection goals for 1995.

Mexico: In June, a total of 10.6 million children were vaccinated against measles, diphtheria, whooping cough, tetanus, tuberculosis and polio during Mexico's third National Health Week. About 2.5 million doses of vitamin A were administered to children aged six months to three years old in 887 high-risk municipalities, and the same number received treatment for intestinal parasites.

Ten million sachets of oral rehydration salts (ORS) were distributed and almost 2 million women were vaccinated against tetanus.

Of school bells and bicycle parts

By Nora Godwin

An unusual sound was heard recently in Lokichokio, the base-camp of Operation Lifeline Sudan (OLS) on the Kenya-Sudan border. Amidst the roar of aircraft arriving and taking off, the shouts of those loading trucks with emergency supplies and the crackle of radio sets, there was the unmistakable clang of a school bell, the old-fashioned, hand-held kind.

It was summoning participants to one of the sessions of Course Alpha, a residential refresher course for teacher-trainers from southern Sudan. This course was a preliminary step of the OLS initiative which is attempting to restore some semblance of normality into the disrupted — and in many cases abandoned — school system in war-torn southern Sudan.

The 41 participants were identified with the help of education coordinators from different regions. The group was largely made up of experienced teachers and teacher supervisors. Their task, once they completed the course at Lokichokio, was to train or retrain groups of teachers in their respective regions and help to get schooling and basic education re-established in communities where 11 years of war have destroyed the educational infrastructure and dispersed both teachers and pupils. By the end of the first stage of the project, it is planned that 600 teachers will have undergone training.

Course Alpha was a two-week-long course in teaching techniques for basic education, in literacy and language teaching, mathematics, health education and communication. It ranged from exploring the use of action-songs for language teaching (when I arrived, I was greeted by the strains of "I'm a little teapot, small and stout" being sung heartily by more than 40 adult voices), to practising strategies to teach simple conflict resolution techniques (the latter being the contribution of Education for Development to the course); from emphasizing the use of familiar items from the immediate environment — leaves, sticks, stones — in the teaching of basic literacy and numbers, to undergoing an intensive training in methods of dealing with war-traumatized children.

This OLS education initiative is a collaborative effort between UNICEF, the United Nations Educational, Scientific and Cultural Organization (UNESCO), the World Food Programme (WFP) and more than 10 NGOs, together with Sudanese counterparts. Part of the initiative also involves providing basic education materials for more than 1,000 schools as well as teacher training modules and textbooks in vernacular languages.

It is highly significant — and commendable — that the regeneration of schools and schooling should have a place among the emergency operations in the region. This is a very definite and positive step towards establishing a future for children and young people in southern Sudan, where childhood has been disrupted by violence and warfare, enforced nomadism, lack of food and health services, and enlistment into the armies.

When the participants finish their course, each will be presented with a bicycle (to get from village to village within his or her "constituency"). They will also be given a stout wooden crate containing papers, pens, chalk, scissors and blackboard paint, and other accoutrements one would not expect to find in a teacher's kit — a duffle bag, mosquito nets, storm lanterns, bicycle parts and — for each — a bright, shiny school bell.

Nora Godwin is the Chief of the Education for Development Section at UNICEF headquarters in New York.

Getting girls back in school in Iraq

By Khalil I. Hamash

Economic sanctions imposed on Iraq have gravely affected education in the country, with drop-out rates sharply up in both primary and intermediate stages.

The most serious impact has been on girls, large numbers of whom withdrew from regular classes under the pressure of economic need, many losing out on achieving basic literacy skills.

To remedy the grave situation, the Iraqi Ministry of Education, the General Federation of Iraqi Women (GFIW) and UNICEF Baghdad have jointly set up a Non-formal Education for Girls Programme.

This programme, designed to improve levels of basic literacy and technical/vocational skills, is reaching approximately 7,000 Iraqi girls (ages 10-14) across the country who no longer attend school.

The programme, which began in April after two months of intensive preparation, offers girls instruction in reading, arithmetic, sewing and child care and includes a monthly lecture on religion.

The collaboration between the partners works well. GFIW has drawn up the general plan, selected and trained teachers and administrative staff, planned the curriculum, supervised and evaluated the project and assumed administrative and financial responsibility. GFIW members also personally visit homes to motivate girls and their families to allow them to join the programme.

The Ministry of Education supports the project by allowing classrooms in its school buildings to be used for classes after regular school hours, providing texts and other supplies and paying the teaching staff.

UNICEF provides sewing machines, stationery and other supplies.

The benefits of the project derive not only from the fact that a sizeable number of girls will be retrained, but that it offers a model of non-formal education that can be replicated in other countries.

Dr. Khalil I. Hamash is Director General of International and Arabic Relations at the Iraqi Ministry of Education.

Five ways to educate all in Pakistan

Developing databases for education-information and enlisting support of the private sector are among the initiatives Pakistan is pursuing, summarized by UNICEF Islamabad:

• The National Education Management Information System collects information at the national and provincial levels on access to and the quality of education.

• Separate directorates of primary education have been created at the provincial level to ensure a clearer focus on primary education and to improve efficiency.

• To encourage private sector involvement, the Government is creating Education Foundations in all four provinces of the country. The foundations will encourage and promote private educational institutions, with a special focus on girls' education and rural area concerns. The foundations will assist the institutions financially, provide some facilities and monitor performance. The Boards of Directors of the foundations, comprised of academicians, entrepreneurs and government officials, are headed by the Chief Minister of each province.

• Neighbourhood and home school systems are being established to encourage the full participation and support of communities.

• In the Province of Punjab a bill to make primary education compulsory will soon be debated in the Provincial Assembly.

India's projects bring education for all nearer

At the Education for All Summit in New Delhi (December 1993), leaders of the nine most populous developing countries reaffirmed their commitment to making "primary education universal and expanding learning opportunities for children, youth and adults" in what is now known as the Delhi Declaration. Here, GEETA VERMA, UNICEF Education Officer in New Delhi, highlights a number of initiatives which are well under way.

The momentum towards achieving Education for All (EFA) by the year 2000 is building. One important factor is government support: this year's education budget was increased fourfold over the previous year's and the Government has committed itself to raising spending on education from the present 3.9 per cent to 6 per cent of the country's gross national product (GNP).

Two recent constitutional amendments are also strengthening decentralization and community involvement in the educational process, important for achieving EFA. The amendments establish a three-tier system of local self-government with key elements of district and subdistrict planning and management and community involvement through elected representatives.

Nationally, the District Primary Education Project (DPEP) has emerged as a major education programme, in which needs are assessed and plans made and managed locally. The project has attracted strong international funding and support: a total of Rs.19,500 million (approximately US$650 million), which includes World Bank and European Community support, has been allocated for 1992-1997, during which time DPEP plans to cover 110 priority districts.

Across the country, other initiatives that states are taking to achieve EFA include:

• In Bihar, the Bihar Education project, supported by UNICEF and the Government of India, is beginning to transform education in seven districts. The project aims to motivate economically and educationally deprived community members to play an active and integral part in achieving universal primary education.

• In Rajasthan, the Shiksha Karmi Project, supported by the Swedish International Development Authority (SIDA), has so far trained more than 2,000 community volunteers as "para-teachers". The new teachers, community members with little formal education and no teaching training, attend a 37-day induction course to prepare for their new role and further training courses for 10 days every winter and 30 days every summer. Thanks to the project, 800 community schools taught by para-teachers have been established in areas that were previously unserved.

• Also in Rajasthan, the Lok Jumbish Project, also supported by SIDA, is transforming education at the village level in 25 development blocks by mobilizing communities and involving them in the planning and implementation of formal and non-formal education programmes.

• In Madhya Pradesh, a virtual revolution in education is occurring through a project that empowers teachers, helping them use existing resources better and design their own teaching materials. Currently, some 5,000 primary schools in five districts are being revitalized through this programme.

• In Kerala, the Total Literacy Campaign aims at making all men and women between the ages of 15 and 35 literate, mobilizing communities through traditional and mass media. The new literacy wave is today sweeping more than 250 districts in the country. And more importantly, the adult literacy programme has created greater demand for primary schooling in communities.

Children's issues find space in the electoral arena

Mr. Mayor,

I cannot give you my support yet, but you, yes, you can give me yours.

Juanita

Juanita: Putting children in the electoral arena, ***a case-study by Colin Fraser and Sonia Restrepo-Estrada.***

This newly published case-study details an information strategy that UNICEF launched in 1989 in Colombia to put children's issues on the country's political agenda during a critical mayoral election campaign. The study highlights the strengths and weaknesses of the campaign, traces its impact and draws important and useful conclusions about the potential to be tapped by information and communication activities.

Juanita, a 10-year-old primary school student, was acutely aware of the problems facing the majority of Colombian children and put down her thoughts in a letter to the future mayor of her village. The letter — simple, direct and strong — became the centrepiece of an appeal organized by UNICEF and sent by Juanita to all mayoral candidates. In a key phrase that touched emotions and won hearts, Juanita said "I cannot give you my support yet, but you, yes, you can give me yours."

Written on a page from her school notebook, the letter explains, "I know that we are lacking schools, clean water, food, health. Our problems are many but there are easy solutions that don't need much money, only that you want to do them."

This case-study not only describes in-depth a highly effective social mobilization campaign that will be valuable to all field offices seeking ways to broaden their impact, but it also demonstrates more generally a new and dynamic role for the information and communication function. Seen by many as secondary and reactive, information and communication in the Juanita campaign proved themselves propellents of political and social mobilization and primary activities that could precipitate change.

Juanita's face and letter appeared in print, on radio and television and on large posters across the country. Mass media were used to reinforce the individual message Juanita sent to each candidate and to create public awareness and pressure at the community level for candidates to include children on their political agendas.

During the campaign, informal analysis showed that the majority of the population had received Juanita's message and had received it favourably. The case-study, acknowledging the campaign's shortcomings as well as its successes, concludes that the appeal was both imaginative and strategically sound.

For a copy of the report in English or Spanish, contact: Programme Communication Section, UNICEF, DH-40, New York, NY 10017, USA. Telephone: 212-702-7145; fax: 212-702-7239.

The Convention changes children's lives

continued from page 1

put on preventing discrimination against girls. In some countries there is an *ombudsman* or a similar institution, and the intention in most cases is to ensure a system of independent monitoring. National commissions with non-governmental organizations (NGOs) have been established in a number of countries.

In sum, the process has helped considerably to give issues related to children more political weight; important discussions have started about national mechanisms to monitor and enforce principles and norms about the rights of the child; a greater understanding is being created about the rights of children as distinct from mere charity.

What is the extent of NGO involvement in implementing the Convention?

In several countries, especially in Latin America, NGOs have joined forces in *coalitions* to advocate for and help implement the Convention. They have reminded governments of the reporting obligations, contributed to the drafting, commented on the reports and in some cases even written their own reports to the Committee.

This has been helped by the fact that NGOs have been present during pre-session Committee working group meetings and have a full-time coordinator now in Geneva whose task is to relate to and support local NGOs in their participation in the process. It should be said, however, that there are also countries in which the NGOs have not managed to play that constructive a role. Here, there is a challenge for the whole international child rights movement.

What impact has the Convention had on laws to protect children in those countries that have ratified the Convention?

There are laws relevant to children in all countries that have ratified the Convention. But they need revision in the light of the principles and norms in the Convention. Such revision — in several cases through adopting completely new legislation — has taken place or been initiated in a great number of countries. This seems to be one of the positive results the Convention has already had.

At the same time, much remains to be done. Some examples: laws against discrimination of girls, laws to protect children from hazardous work, ban on child prostitution, good legislation in cases of adoption, protection against detention in contradiction of the Convention. One important means towards genuine realization of the Convention is education and training of personnel working with children: a deep understanding among these professionals of the idea that the rights of the child should be immensely important.

How can the Convention be enforced?

The Convention was drafted by governments and adopted by them. With good will it is possible to implement the Convention.

There are some articles, relating mainly to the economic and social rights in the Convention, that require resources for full implementation, which can occur gradually. Implementation will be more difficult in poor countries. This is why there is also a provision in the Convention about international assistance — and this is an important aspect which the richer countries should take more seriously. The 20/20 initiative is the most important for the rights of the child.*

Programmes of structural adjustment have been enforced in most countries during recent years; this has been an economic necessity. How do these policies relate to the rights of the child?

UNICEF and others have discussed *structural reform with a human face*, the intention being to create safeguards against cuts with severe social consequences. The World Summit for Children in September 1990 called for reforms to promote world economic growth, "while ensuring the well-being of the most vulnerable sectors of the populations, in particular the children." That is in the spirit of the Convention on the Rights of the Child. Countries with more resources should offer services to children on a higher, absolute level than is possible for poor countries. The resources should not be seen as static.

And all governments — irrespective of financial resources — should put plans in action to start implementing all aspects of the Convention. In the Committee we are keen to see *political will* demonstrated by the governments.

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* Editor's note: The 20/20 policy, supported by UNICEF, UNDP, UNESCO and UNFPA, proposes that all donor countries ensure that 20 per cent of their official development assistance (ODA) goes to meeting basic human needs in recipient countries. In countries receiving development assistance, governments are asked to ensure that 20 per cent of their budgets go to meeting the social and development needs of their people.

Investment and land reform could lessen Latin America's poverty

The roots of poverty in Latin America are examined in depth in a new Innocenti Occasional Paper, *Macroeconomic Policy, Poverty Alleviation and Long-term Development: Latin America in the 1990s*, by Giovanni Andrea Cornia.

This well-researched analysis highlights the economic growth and poverty trends of the 1970s and 1980s in the region. It cites insufficient capital accumulation, income inequality and inadequate and inequitable access to education as the major causes of poverty in the 1980s. The second half of the study suggests remedies and interventions for the 1990s and outlines policy measures needed to tackle problems over the next two decades.

The author suggests that countries in the region adhere to a new development model, adopted by the nations in East and South-East Asia, as well as by Chile. This new model of growth and political economy is characterized by, among other elements, a longer policy-making horizon, a more equitable distribution of land and sustained investment in technology and human capital.

For a copy, contact: UNICEF International Child Development Centre, Spedale degli Innocenti, Piazza SS. Annunziata 12, 50122 Florence, Italy. Tel: 3955-234-5258; fax: 3955-244817.

The Convention at work in Romania

Breastfeeding is one of the cornerstones of a new initiative by a Romanian NGO which is helping keep families together.

By Cristina Verona

At Vilcea's Maternity Hospital, 26-year-old Maria prepares to breastfeed her newborn baby girl. It is her eighth baby — the first she has been allowed to keep with her after birth. Because Maria decided to place her other children in institutions, she was able to see them only when they were brought to her at regular hours to feed them.

"I had no money, so I put each of them in an institution," she says candidly. "But now, I am no longer sure I want to give this one away. She looks so small and helpless. I am very happy I can spend every minute of my day with her."

Maria decided to keep her daughter, thanks to a 'rooming-in' and breastfeeding programme that encourages mothers to bond with their newborns. The programme, in place now for two years and instrumental in averting the abandonment of 40 children, is one of several low-cost, targeted interventions of Salvati Copiii (Save the Children). The non-governmental organization (NGO) was founded in mid-1990 by Dr. Dragos Serafim, head of the Paediatrics Hospital in the area. It uses the guiding framework of the Convention on the Rights of the Child to improve the lives of thousands of children in Rimnicu Vilcea, a county of 430,000 people in southern Romania.

Focus on women and mothers

Improving the health, nutrition and education of women, Salvati Copiii believes, is the best protection for children. Its 260 members — including specialists in early childhood development, special education and community outreach — focus on several key areas.

Along with the rooming-in initiative, a team of young doctors at Vilcea's obstetrics clinic at the Maternity Hospital has reorganized delivery wards, intensive care rooms and the family planning centre to promote maternal health.

The family planning centre offers free advice on modern methods of family planning from the pill to the IUD, in an effort to reduce the number of abortions, which soared when the pro-natalist policies of the former regime were rescinded. Nearly 600,000 abortions were performed in Romania in 1993, one of the highest rates per capita in the world.

In Vilcea, the number of abortions has dropped significantly, from 22,400 in 1992 to 20,996 in 1993, a decrease doctors attribute to wider availability and more active promotion of family planning methods.

"We have succeeded in convincing many women to choose modern family planning methods over the physical and psychic trauma of an abortion," said Dr. Martin Stoica, the clinic director. "But to change mentality is hard work."

Ironically, a three-month supply of unsubsidized birth control pills in pharmacies costs 5,000 lei (US$3), more than the price of an abortion: 3,000 lei (US$1.80). Doctors at the obstetrics clinic fear that higher abortion fees could lead to more self-induced abortions.

The difficult transition to a market economy has taken a toll in social welfare. The country's infant mortality rate — 24.5 per 1,000 live births in 1993 — is 10 per cent higher than in 1992 and is the second highest in Europe after Albania's.

"The greatest of all obstacles we are encountering at the moment are premature births caused primarily by poor living conditions and nutritional deficiencies in mothers," said Dr. Serafim. "Many women are malnourished."

A new project will identify women who are at a high risk for early delivery and provide them with specialized care. The project will reinforce gains already made in reducing infant mortality in Rimnicu Vilcea over the past few years, down from 20 per 1,000 live births in 1990 to 15.3 in 1993.

The programmes conducted by Salvati Copiii to reduce infant mortality include: early diagnosis and treatment of respiratory infections in newborns (a main cause of death in children under three); the introduction of parent-held health records to keep track of the child's development; and the promotion of breastfeeding to strengthen the child's immune system.

In a two-pronged strategy, curative services will be offered and a preventive approach taken, using radio and television to educate families and communities about sexually transmitted diseases, modern family planning methods, child immunization and breastfeeding.

Breaking down institutional walls

Nearly 2,000 children are institutionalized in Vilcea, a small but important fraction of the 100,000 in institutions throughout Romania.

"Our aim is to convince the families to take back their child, and sometimes they do," said a nurse, holding three-month-old Albert-Adrian, whose mother had abandoned him for economic reasons.

Helping disabled children leave institutions and return to their families, or rehabilitating them to live independently, are important goals of Salvati Copiii, which works with other international agencies with similar goals. It has assisted a US-based organization, Project Concern International, in establishing a transitional living centre (TLC) in a 25-room manor house in the village of Maldaresti, 30 kilometres south-west of Vilcea, where currently seven disabled children, aged 16 to 21, are learning to lead autonomous lives.

Valentin, a 17-year-old resident, has learned the concepts of space, time and money there, as well as how to write and to paint. "This is my house," he says, showing his drawings.

After 12 months of training, the young people will be assisted in finding jobs and accommodation. TLC Director Meresiev Barbuc and Dr. Serafim of Salvati Copiii are planning to set up a local consultative council to discuss ways to integrate the disabled into the community. The council is expected to provide jobs in construction as well as fruit and vegetable picking. The project will involve police, factory directors and entrepreneurs. "It's essential to enlist the support of the community," said Mr. Barbuc.

The case for caring

Nicoleta, aged five, is one of Salvati Copiii's and Dr. Serafim's most striking signs of success, proving that individualized support and care can work wonders.

During her years of institutionalization, Nicoleta had become aggressive and unsociable, hurting herself physically, throwing frequent temper tantrums and making it difficult for even her parents to give her support.

At the Pediatric Hospital, Nicoleta received psychological counselling and attention — rather than medication — and is now a friendly, happy child.

Her parents are planning to take her back home, where her development will continue to be supervised by health officials.

Nicoleta's transformation may be miraculous, but according to Dr. Serafim, no miracle drug was responsible. "Nicoleta was cured with love and affection," he says.

Cristina Verona is a freelance writer.

Comic strip teaches teens about sex

By Sara Cameron

Teenagers in the Caribbean can't stop talking about Sam and his girlfriend Trish, characters featured in the new comic strip, *The Sex Patch*.

Sam, a languid teenager, is in love with Trish, but they are not having sex. Their self-control is thanks to a miracle of science fiction known as the 'sex patch', designed to dampen the sexual urge when worn.

The Sex Patch comic strip, published with assistance from the United Kingdom Committee for UNICEF, chronicles this typical teenage relationship, highlighting the pressures and difficult choices young people today must make.

The first time Sam is given the patch, he's told, "There are literally dozens of things you can do instead of having sex!" Trish is also wearing a patch, and the two discover the thrill of sexual abstinence and new ways to enjoy one another's company.

Yet they don't live happily ever after. Sam likes to live dangerously — "a rebel without an urge" — and dreams of tearing off his patch. He ultimately falls prey to Eve, a woman who is patchless, confronting a serious dilemma: what to do when a girl says "yes."

The comic strip is making some Caribbean teens laugh, since they can get a real sex patch. Yet while the comic strip is amusing, the messages it conveys are extremely serious.

UNICEF's life-skills programme for the region encourages teens to make responsible decisions about their sexuality.

Such decisions are critical on islands where a significant number of infants are born to teenage parents, where sexual activity among the young is reportedly high and where the rates of HIV/AIDS are among the highest in the world. Surveys in Barbados and Jamaica have suggested that 50 per cent of teens are sexually active before reaching age 16.

The Sex Patch is a tool for parents, schools and community groups to bring discussions about sexual behaviour into the open. Teens are being encouraged to look at sex dispassionately (as Sam and Trish do), to think about the consequences of the choices they make and to assess what they really want from life.

Laughter has long been used as a tool to break down barriers on taboo subjects. Sam, Trish and *The Sex Patch* are doing their bit to bring some comic relief to a topic that is deadly serious for Caribbean youth today.

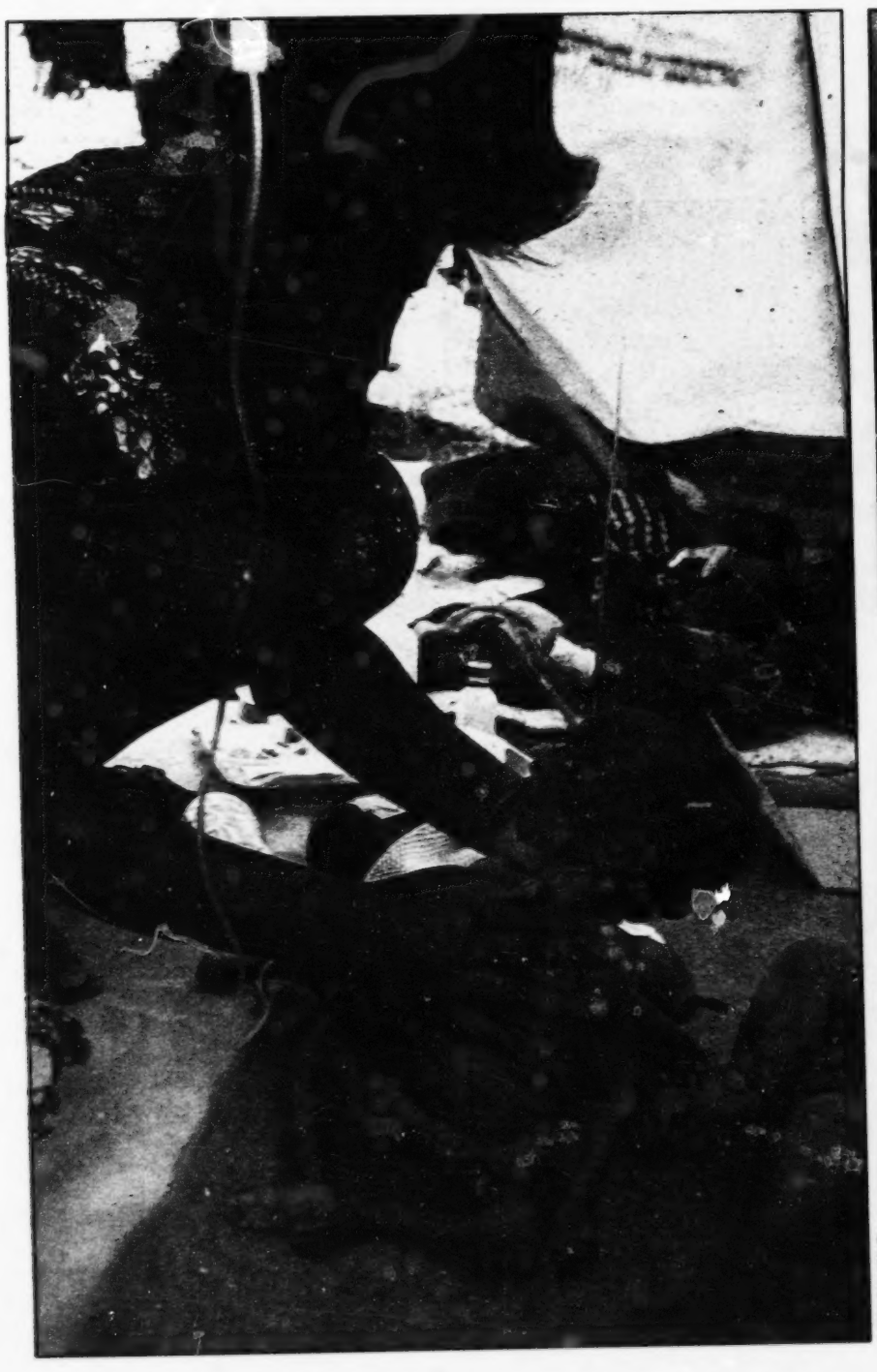
Sara Cameron is a writer who lives in Barbados.

Scenes of horror and hope fro

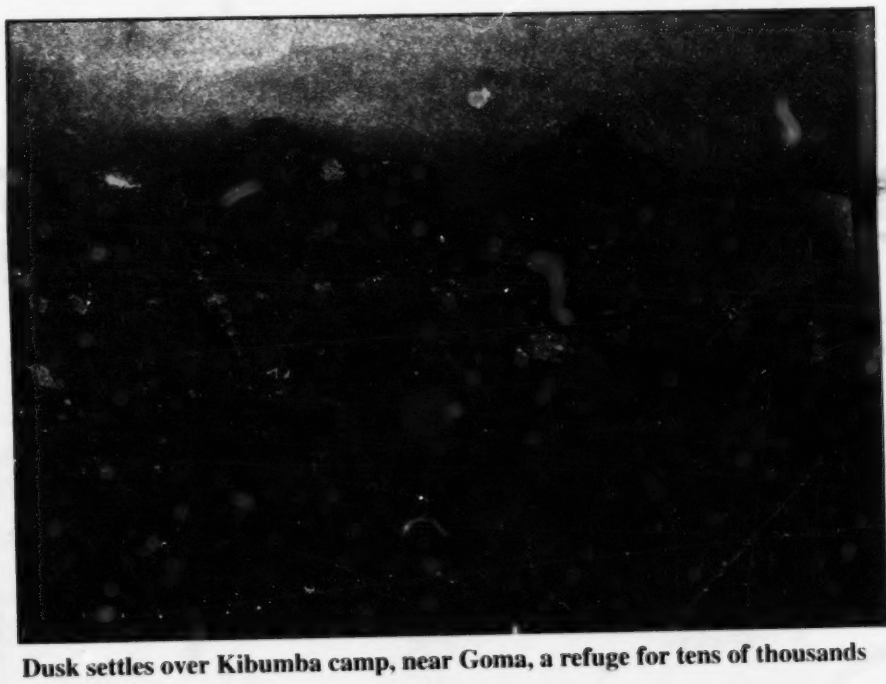
UNICEF/94-0184/Press

In the turmoil of war, many children who became separated from their parents and families turned to each other for support. Here a boy carrying a younger child joins others waiting to be registered by relief workers in the hopes of finding their parents.

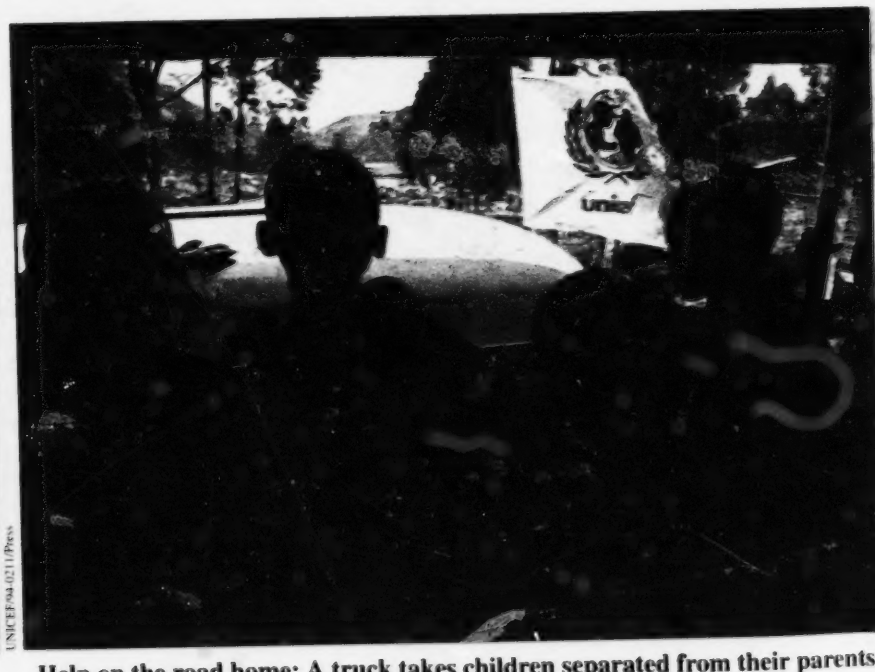
UNICEF Goodwill Ambassador Harry E
Rwanda.



A health worker trained by CARE Australia takes the pulse of a seriously ill and dehydrated infant in a camp near Goma (Zaire).



Dusk settles over Kibumba camp, near Goma, a refuge for tens of thousands of Rwandese.



UNICEF/94-0211/Press

Help on the road home: A truck takes children separated from their parents to a UNICEF-assisted camp for unaccompanied children run by the NGO, Caritas.

om Rwanda

Belafonte cheered up children separated from their parents at a centre in

Mothers, hoping to find their children, wait at a centre for unaccompanied children on the outskirts of Kigali.

Immunization under fire in Rwanda

By Paula Claycomb

A football stadium in Rwanda's capital was one of many places transformed to bring the gift of life to thousands of children. For two weeks in late June, the Kigali stadium was one of the sites of a UNICEF vaccination initiative, supported by the Ghanaian medical team of the United Nations peacekeeping force in Rwanda and by Médecins sans frontières (MSF).

Because all vaccination activity had stopped when the fighting began in Rwanda in early April, millions of children were vulnerable to illness. A vaccination campaign was needed to prevent a massive outbreak of disease, including measles — highly contagious and deadly for children living in deteriorating conditions.

Because the airport was closed due to mortar attacks, the vaccines had to be transported by road to southern Uganda by UNICEF immunization specialist Robert Davis, who had come from Somalia to launch the campaign.

Carrying fragile measles vaccines, needles, syringes, cold boxes and other immunization equipment, Davis then travelled to Kigali with a World Food Programme truck convoy, through zones controlled by the Rwandan Patriotic Front.

Stadium, hospital, airport

In the football stadium, which had quickly become one of the largest safe havens in Kigali for unaccompanied children and for men and women forced from their homes by the violence, vaccinators used megaphones to mobilize mothers and children to come to the vaccination site under the grandstands, where MSF ran a clinic.

At King Faisal Hospital, UNICEF staff, the Ghanaian medical team and MSF clinical staff travelled through the corridors to locate all of the children camped out there, giving vaccinations on the spot. And just as the crew was finishing its work in King Faisal, a hundred new patients were brought in by the Red Cross, evacuees from another hospital which had fallen under mortar fire. They were vaccinated against tetanus.

The hundreds of Rwandese who had fled the fighting and taken shelter at the airport were the easiest to mobilize for vaccinations. The airport freight compound had been turned into a makeshift village with cargo containers being used as living, dining and bedrooms, and plastic sheeting as carpets. A camp commander kept the crowd well organized, and when he told the group to present itself to the Ghanaian medical clinic, everyone promptly arrived and the children were quickly vaccinated.

During the emergency immunization campaign, in Kigali alone, 2,043 children were vaccinated against measles and 719 pregnant women were vaccinated with tetanus toxoid, protecting their unborn children from neonatal tetanus.

Prior to the fighting, Rwanda had had one of the best immunization programmes on the continent, and while these emergency vaccination campaigns have reached thousands of children, peace is the only hope for their healthy future.

Paula Claycomb, a UNICEF Information Officer, was on emergency assignment in Rwanda.

A child enjoying water-on-tap, a UNICEF initiative in Rwanda to reduce the risk of cholera and other infections.

Minas Gerais sets example in education

By 1990, 95 per cent of children in Brazil had access to primary education. Yet drop-out and repeat rates remain high in many areas, demonstrating that children need more than just access to succeed academically. Last year, the state of Minas Gerais received the 1993 UNICEF Brazil 'Child and Peace' award for its commitment to improving the quality of education. RACHAEL LAVENDER reports on the strategies that are working.

For the state of Minas Gerais in Brazil, 'Education for All' means more than just building classrooms. It means providing children with quality education that will enable them to be productive adults.

Three years ago, with strong backing from the state Governor, the Department of Education in Minas Gerais began taking steps to improve the quality of education by transferring power into the hands of the schools and local communities.

"Our main goal is to ensure that schools have autonomy," says the State's Secretary for Education, Walfrido Dos Mares Guia. "If we can achieve this, then our communities will start to consider schools and education as their problem and not just a problem of the Government."

In a departure from the traditional system in which senior-level positions are generally political appointees, school directors in Minas Gerais are now chosen in a more democratic process based on merit. Three candidates are selected from a pool of applicants who must pass a stringent written test. These candidates must then present their educational philosophy and their plans for the schools to all the teachers, parents and students from the area schools. The group votes for the person they believe will best perform the job.

Mr. Dos Mares Guia explains that this was an essential first step. "It had a very important impact because it was a symbol that things were going to change."

The next step was to establish *colllegiados* (or school boards) with a membership composed half of teachers and half of parents and students. The boards allocate funds to run the school and they also establish the school's educational policies. Today, all state schools have school boards and the system is spreading to municipal schools as well.

To improve the quality of teaching, the Department of Education has implemented a teacher-training programme as well as an external evaluation system, creating a new career structure that promotes teachers based on individual merit. "Teacher training is a very important programme," says Mr. Dos Mares Guia. "It will improve the way subjects are taught and how students' progress is monitored."

Equally important, teachers are trained to enhance the self-esteem of their students, helping eliminate the 'failure mentality' that leads many to drop out. "Success is the best thing for success," says Mr. Dos Mares Guia, "and the teacher is the most important instrument in ensuring that success."

Mobilizing for success

The structural and administrative changes provided a strong foundation to improve the quality of education. These received a boost in January 1994, when members of the business community, trade unions, church, community leaders, governmental and non-governmental organizations all came together to create the Minas Gerais 'Pact for Education', with a clear manifesto of what needed to be done to improve education in the state.

Spurred by the Pact, local groups around the state have been meeting to devise their own specific educational strategies. "The plan is to make local pacts within all the municipalities, to give each city ownership of its own education," says Demostenes Romano, a member of the Pact for Education.

A key feature of the Pact is autonomy, enabling each organization to address its individual circumstances. From factories ensuring that all their employees' children have notebooks for school to a mining operation paying for the printing costs of the Pact for Education's manifesto — across the state, improving the quality of education is on everybody's agenda.

"UNICEF support for the Pact gave us the necessary backing to mobilize the many and varied sectors we needed to make this a success," explains Mr. Romano.

Minas Gerais is ideal as a model for change. The state stands as a frontier between the disadvantaged north-east of the country and the more prosperous, industrialized south-east, with elements of both within its borders. With the participation of all sectors of society, the Pact for Education is in a good position to stimulate similar movements for education, not only throughout Brazil, but also in other countries.

Until now, major obstacles to change have been the alterations in educational policies made each time a new political party came to power. The Pact for Education will ensure continuity as new education polices emerge. To the state Secretary for Education, the Pact is "like a light that embraces all our work, and gives us the strength to carry it out."

In a country where the problems of ensuring quality education are more political than technical or financial, the social mobilization work of the Pact for Education is the key to change. The striking red, white and yellow Pact for Education poster calls on people to "Imagine a country where all children go to school."

And then it offers a reminder that dreams can come true. "Brazil could be this country. Minas is showing the way."

Rachael Lavender is an Information Officer at the UK Committee for UNICEF.

Electronic information: Extending UNICEF's reach

By Edgar Koh

Advances in the field of electronic information and communication in recent years offer UNICEF unprecedented opportunities as it seeks to enlist more and more partners in the cause of children.

Because of the current phenomenonal expansion in global electronic networking, information can now not only be compiled more efficiently, stored more compactly and retrieved more quickly than before, thanks to such innovations as searchable databases and CD-ROM, it can also be communicated more rapidly and systematically to more users.

UNICEF needs to position itself strategically to benefit from the electronic information revolution now upon us. The virtual global village, brought into existence by the information superhighway, offers UNICEF numerous mobilization, advocacy and fund-raising possibilities.

This need has arisen because electronic networking has become a fact of life in the last two years, not only in the industrialized world but in many developing countries as well. UNICEF New York has now established a full-service node on the Internet, the largest amalgamation of inter-communicating electronic networks in the world. Linking together more than 2 million host computers serving at least 20 million users in over 100 countries on six continents and expanding at the rate of 10 per cent a month, the Internet enables people and organizations to send electronic mail, log in to remote computers, search databases in far-flung locations and retrieve and download the information so gathered.

Access to the Internet

According to the Information Resource Management (IRM) Office (UNICEF New York), most UNICEF House staff will have access to the Internet via a local area network (LAN) by the end of 1994. UNICEF and National Committee staff in 50 other countries also have or will soon have access to the Internet, either through a commercial service provider or through a non-profit gateway such as Childnet or Greennet.

The Internet is a more open system and offers more ready access than UNET. Thus, the IRM Office expects that field offices and National Committees will be brought on-line quicker than would be the case with UNET, which is likely to be phased out in the medium term.

The real potential of the Internet, however, clearly lies not only within but beyond the UNICEF family. The Internet will enable UNICEF to venture effectively into the new and exciting world of electronic publishing and conferencing. UNICEF will be able to place information on the Internet (and on other electronic networks such as Peacenet, Agora and the World Press Centre) for retrieval by audiences already familiar with their own systems and ready to select information from various network databases. Many of these users will also be able to take part in discussions and consultations on issues of interest to UNICEF, such as Childnet conferences on the Convention on the Rights of the Child and on children in especially difficult circumstances.

Using the Internet is an efficient and powerful way to raise awareness and to build support for child-related causes among individuals and NGOs. Many NGOs, indeed, seem to have an affinity for the Internet, perhaps because it enables them to act — or at least to communicate — globally as well as to think globally.

Publications can also be distributed in full text on CD-ROM as well as hard copy. Information compiled in such an electronic manner can be completely indexed and easily searched by subject or other keywords.

In the longer term, UNICEF will have to develop an adequate electronic information capacity to take advantage of new trends such as image archiving, interactive multimedia CD-ROM that combines text, sound, still images and video. It also transmits and remotely prints graphics and other information material.

Joint action among agencies

Inter-agency cooperation in computer and electronic applications in public information began in 1992 with the establishment of a Joint United Nations Information Committee (JUNIC) technical advisory group.

Opportunities for synergistic cooperation exist in the following areas: databases; bulletin board services; electronic conferences on major development themes and global events; electronic storage and transmission of texts; graphics and photos; faxes on demand; and remote printing and publishing.

JUNIC has called for the setting up of a common UN public access bulletin board service that would draw from the databases of the UN Secretariat and participating UN agencies.

In preparation for 'going Internet', the UNICEF Division of Information (DOI) has revamped the editorial content and format of its databases and bulletin boards, discontinuing UNET services that were considered too costly or of marginal relevance or both.

In their place, DOI has developed and is maintaining databases offering the full text of *The State of the World's Children* report and summary, *The Progress of Nations*, UNICEF Features, *First Call for Children* and the final drafts of other publications. These electronic versions are released before hard-copy distribution, thus giving a production head start to National Committees and other users wishing to translate or adapt them for their own publications and audiences.

In June 1994, coinciding with the release of *The Progress of Nations*, DOI — in cooperation with the IRM Office — launched a 'gopher service' on the Internet, offering to millions of users worldwide the full text of UNICEF public information publications, plus the Convention on the Rights of the Child and the Declaration and Programme of Action of the 1990 World Summit for Children.

A 'gopher' is simply a hierarchical series of menus leading eventually to

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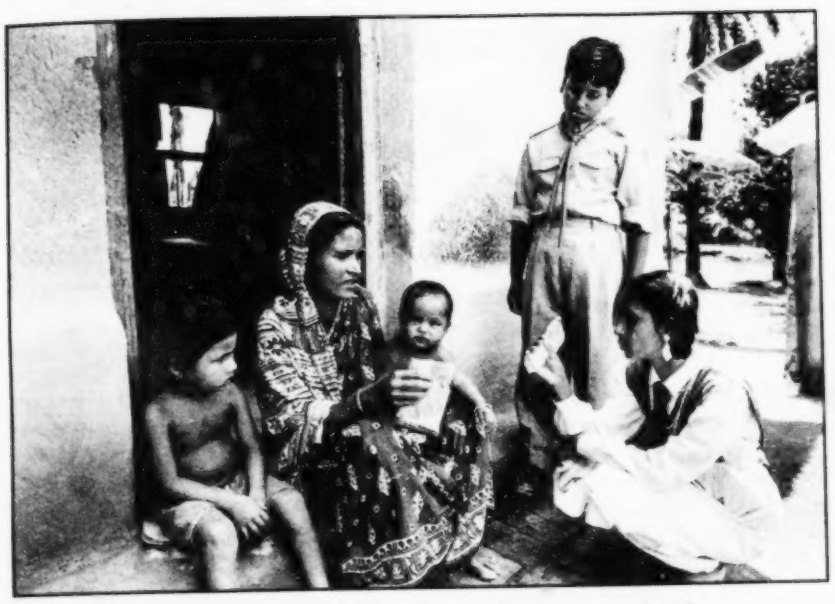

UNICEF Nepal

A Girl Scout explains oral rehydration therapy (ORT) to a mother in Bangladesh.

ORT campaign boosts use rate in Bangladesh

By Michael Galway

Beneath a moody, black sky in the small village of Bahadurpur, fields are turning different hues of green. It is a familiar scene during the rainy season in Bangladesh. The difference on this day is the song drifting across the rice paddy:

When you suffer from diarrhoea,
sugar, salt and pure water —
mixed together and taken timely —
make diarrhoea fly away.

The song was composed by Manzoor Murshed and his friends, members of the Boy Scout movement in Bangladesh, in the traditional style of the *jari* or folk-song. The lyrics clearly are not traditional.

They were written to help villagers learn about life-saving oral rehydration therapy (ORT). As he sings them, Mr. Murshed mimics the motions for mixing sugar, salt and clear water, the acclaimed formula established 25 years ago by researchers in Bangladesh and India. At current use rates, ORT saves the lives of more than a million children around the globe every year.

In Bangladesh, some 50 per cent of diarrhoeal cases are now treated by ORT or recommended home fluids, such as rice water. Still, every year 250,000 children under five years of age die from diarrhoea in Bangladesh, one child every two minutes. Raising the use rate will save lives, and by the end of 1995 the country hopes to reach 80 per cent usage.

The Scouts movement is an important player in this effort, helping promote ORT in villages across the country. They have launched intensive ORT awareness campaigns in 15 pilot villages, where rallies are held, *jaris* performed, posters distributed, surveys conducted, door-to-door visits carried out and contacts established with government officials and village leaders. In the pilot villages, more than 85 per cent of the population now know about ORT. Another 600 villages are the focus of a less intensive ORT campaign.

Thanks in part to the Scouts' efforts, this year in Bahadurpur not one diarrhoea-related death has been reported. The Scouts have encouraged families to build latrines and draw water only from safe sources. The Scouts also stress education, and a greater number of the children are attending school.

Aklima Muzammel Haque, 11 years old, is a Scout and a part of this movement in which children are helping children. Aklima can remember showing her mother how to use ORT when her baby brother was sick from diarrhoea. "It saves lives," she says, beaming with confidence.

Many obstacles still remain. Parents often believe that ORT will 'cure' diarrhoea and when this does not occur, they stop using it. Or some restrict food, thinking that will stop diarrhoea, while in fact it only weakens the child further. Many doctors still mistakenly consider ORT 'unscientific' and thus do not recommend it, instead prescribing expensive antibiotics or intravenous fluids.

Donors, UNICEF and other United Nations agencies are collaborating with the Government to accelerate the education of health workers and the public, promote the building of sanitary latrines and motivate the private sector to market oral rehydration salts (ORS).

The growing participation of grassroots groups such as the Scouts, supported by international agencies, and the encouraging examples of villages such as Bahadurpur, all seem to indicate that Bangladesh will reach the mid-decade goal of 80 per cent use of ORT.

Michael Galway is a freelance writer in Bangladesh.

On the air in Mongolia

By Sarah McNeill

The horseman shouts a message as he approaches at full gallop. His horse neighs and the two gallop away — all with the excitement of a Hollywood Western. But this is not the Wild West, this is Mongolia — home of Ghengis Khan and once known as the 'lost country' of Central Asia.

The horseman's message was for Sukhbaatar, Mongolia's hero of the 1921 revolution. The sequence described above (an excerpt from a film as well-known in Mongolia as *Casablanca* is in the West) is featured in the first UNICEF spot for Radio Mongolia, produced during a two-week workshop earlier this year and broadcast on 20 May to launch a 10-day immunization campaign.

Radio is an important communication tool in Mongolia, where communities are scattered across vast distances. Broadcast on both AM and FM by cable and using six transmitters, Mongolian Radio has 2.3 million potential listeners.

The radio spot was an unfamiliar genre for the broadcasters and programme designers who participated in the workshop. At the beginning, few of the dozen or so participants trusted that a 30-second spot could effectively convey a serious message.

As organizer of the event, I had brought demonstration tapes providing 10 examples of radio spot production. One soap opera-style piece had been scripted and translated into Mongolian, providing six items of information in a brief 30 seconds. Another 60-second example from the ABC network in New York squeezed in three songs and an interview with Barbra Streisand. The variety of examples provoked discussions on formatting, targeting audiences and scheduling.

During the first week, workshop participants reviewed and practised radio-interviewing techniques. Daring ways of scripting and formatting were tested; some worked, others did not.

The Mongolia version of *Facts for Life* (FFL), a joint United Nations agency publication that gives simple and clear health messages, was used throughout the workshop. During the early group meetings, four messages were selected for the radio spots — two on immunization and two on breastfeeding. As the country's school children were about to commence their three-month summer vacation, the group also decided to base one of the spots on the new UNICEF *Child-to-Child* publication, which focused on accident prevention and safety in the home.

Conveying a familiar message

The first radio spot produced was eight minutes long. However, the Schedule Controller said it would be difficult for him to find a slot on the schedule for a piece longer than two or three minutes. The Immunization Campaign Director, Dr. Naryan, also felt listeners would not be able to remember so much information.

The production team worked hard to cut their creation and by the following day, a 1-minute 45-second radio spot was ready for transmission, complete with a quote from the Sukhbaatar film.

It was significant that as the team edited the piece, they stuck to the original plan to include the film clip. "Take this message to Sukhbaatar. It's urgent!" shouts the horseman. In the radio spot, these words emphasize the urgency and importance of immunizing the country's 360,000 under-fives.

M. Nevill

Girls in kindergarten in Ulaanbaatar (Mongolia). Some of the country's broadcasters are now using radio spots to promote children's health.

An important lesson had been learned — to convey the message in familiar terms so that a listener 600 miles to the east or a thousand miles to the west of the capital would relate and respond.

The Mongolian radio producers incorporated all the principles of ownership, familiarity and recognition in their productions: a radio spot on breastfeeding included an interview with Mongolia's renowned wrestling champion, Baljinnyam. In a comical spot on oral rehydration therapy, a celebrity comedienne performed a skit on diarrhoea.

The children's spot on safety was made by recording telephone interviews with a boy and a girl on school holidays, whose parents had locked them in before leaving for work. This is fairly common practice in the main cities, the alternative being for children to spend the day out on the streets.

The safety message was incorporated into this spot by asking each child what precautions his or her mother had said to observe. The boy remembered nothing. The girl recited four rules: "Don't turn on the taps; don't switch on the television; don't touch the iron; and don't go near the kitchen stove." A timely reminder for any parent or child about how accidents can occur.

This collaboration between UNICEF and radio producers is an innovative development in creating basic health and safety messages to help protect the children of Mongolia.

Sarah McNeill is the co-director of Unlimited Productions, a radio production company in England.

The Bamako Initiative

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January 1994

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The Bamako Initiative: A primary health care vision for the year 2000

"A locally self-supporting primary health care system for all of Africa by the year 2000 — with children immunized, parents empowered with knowledge to promote and protect the health of their children, and essential drugs for all."

This is the vision of the Bamako Initiative outlined by UNICEF Executive Director James P. Grant and later adopted by participants at a regional meeting of the World Health Organization (WHO) in Bamako (Mali) in 1987.

At this meeting Mr. Grant also emphasized the importance of partly financing local primary health care through the sale of vital drugs. "When families become accustomed to using a centre regularly because they know it is a good source of medicine, they use it for other purposes as well," he said.

This historic meeting set the Bamako Initiative as a target for all African countries, and inspired other countries elsewhere in the developing world to adopt a similar approach. Steve Jarrett, Deputy Manager of the UNICEF Bamako Initiative Management Unit (BIMU), points out that only a set of basic operational principles are available to countries to help create the framework for implementing the Bamako Initiative. "There is no unique model," he says. "The Initiative is a series of reforms which requires the participation of everyone, from the community member who uses the health centre up to the central government. The UNICEF Executive Board has best captured the essence of the Initiative in labelling it a 'community-focused health sector development'."

Community involvement in managing and financing local health services is critical to improving service quality and ensuring long-term sustainability. "Community involvement beyond paying for services has been one of the most difficult aspects to implement," says Mr. Jarrett, "as this challenges the traditional relationships between health worker and patient."

Under the Bamako Initiative, a typical programme is run by a management committee which has from 4 to 30 members, who use varying styles and approaches of organization, depending on the local culture and mix of villages represented.

Management committees are increasingly overseeing health workers who previously had simply been hired by the central government and assigned, unsupervised, to health centres in rural as well as urban areas. A lack of accountability on the part of these workers proved to be a serious problem. Committees have adopted a supervisory role and almost everywhere have also devised incentive payment plans to motivate health workers. They hope thus to develop a stronger bond between the community and the health centre.

Under the Bamako Initiative, a district, country or region chooses what it considers to be the best method for financing basic health services. Community funds, for example, can be raised through payment for drugs, charges for services, registration fees or local taxes. For instance, Benin and Guinea use a fee-for-service system. Sierra Leone and Nigeria determine payments based on drug sales. Burundi has tried to adapt an existing prepayment system. The experience so far indicates that the poor prefer paying fees for drugs and

services, as and when they need them, to prepayment, insurance or other indirect payment methods.

Essential drugs are a key component of the Bamako Initiative, forming an integral part of primary health care and lending credibility to health services. With drugs affordable and readily available and with increased knowledge and improved health associated with their wider use, inappropriate, unnecessary and incorrect prescriptions are likely to diminish. The Initiative also actively seeks international assistance in providing essential drugs and improving service. It is hoped that such aid will stimulate even greater local community investment.

While many countries in Africa have started implementing the Bamako Initiative, some issues will only become clear in the next two to three years as a result of operations research that is currently under way: the access to health care for the very poor who cannot afford to pay; the rational use of drugs, given a more continuous supply; the ability of governments to maintain support in the face of declining economies; and the role of women in community action. It is evident that some regions will be unable to cover the costs of health care in the long term, meaning that either fewer services will be provided or more effective forms of subsidies will have to be mobilized from government or external supporters.

"The resources and revenues are often available in only very limited amounts. In the end, choices need to be made, and it makes more sense for the people themselves to be fully involved in making those choices that affect the quality of the basic health care they receive," says Mr. Jarrett.

Budget crunch produces community-based alternatives

Community-run primary health care has emerged as a trend of the 1990s. As basic health services run short of money and deteriorate in many parts of the world, community-managed alternatives are being developed to meet the needs and demands of the people.

The first regional effort to offer an alternative originated in sub-Saharan Africa, where health service failures reached crisis proportions in the 1980s. Debt, falling export prices and military spending forced many governments to slash health budgets. Health workers went unpaid, drugs became scarce for long periods, and the maintenance backlog of equipment and vehicles grew.

For the wealthier urban dwellers, there was an option of private, for-profit health services. But for the much larger, poorer, scattered, rural population, modern health services were practically non-existent.

As problems in health care worsened in Africa in recent years, governments and international agencies searched for sustainable solutions.

UNICEF conducted extensive research into the adverse effects of economic and structural adjustment on health care in African countries. The findings were published in 1987 in a report entitled 'Adjustment with a Human Face'.

The report argued that low-cost primary health care and a new social mobilization effort could save millions of young lives if governments in Africa rethought their priorities, especially in health care expenditures.

Most national budgets, according to UNICEF findings, continued to favour high-cost curative care for a small urban élite, at the expense of low-cost preventive measures desperately needed by the poor rural majority.

As an alternative, UNICEF recommended that governments reduce spending on urban hospitals and direct the funds to training health workers and providing equipment and supplies for health posts and community centres in rural and urban slum communities.

In September 1987, African Ministers of Health gathering in Bamako (Mali) for the thirty-seventh session of the World Health Organization's Regional Committee for Africa, discussed the crisis situation with WHO and UNICEF representatives and explored long-term alternatives.

The participants, including the heads of WHO and UNICEF, developed and adopted a new strategy for providing accessible, affordable and sustainable health services in sub-Saharan Africa. The aim was to transform 40,000 government health facilities into a new kind of health service controlled by, and responsible to, the communities it was intended to serve. Thus was born the Bamako Initiative.

As part of the new strategy the Ministers of Health agreed to provide sufficient resources to improve primary health care in their countries, to use their health budgets for the benefit of the largest and neediest section of the population and to explore creative approaches to community financing methods.

Following the initial agreement, UNICEF worked with WHO to develop a guide to

implementing the Bamako Initiative. Four key features were identified as essential elements.

First, an accessible health care delivery network for the entire population. Most countries require a revitalization of the existing network of health centres, enabling trained, skilled and mobile staff to provide basic care and to reach out to more remote villages. A major challenge is to improve the network by strengthening the links between the health units and the district hospital, creating a comprehensive system and thus ensuring different levels of care.

Second, a regular supply of essential drugs and medical equipment. Generally, central medical stores supplying the network of health facilities have been poorly managed. Workers often lack motivation and stocks are continually short, with excessive amounts of expired drugs. To ensure a regular supply of essential drugs and equipment, the Initiative helps individual countries identify sustainable mechanisms for timely drug procurement and distribution. For instance, through the UNICEF warehouse in Copenhagen, participating countries are able to purchase basic essential drugs in bulk at low prices. Besides buying basic drugs and medical supplies, the network also requires an efficient system of warehousing, transportation and delivery to the most remote health centres.

Third, a reliable financing system. The Initiative identifies and recommends the development of two existing sources of funding. The first consists of central government resources that are dwindling but can be reallocated more efficiently for the benefit of a larger section of the population. The second is community spending on health services, particularly for quality health care and pharmaceuticals. Even in the poorest countries, between 5 and 10 per cent of the family income is spent regularly on fees for doctors, clinics, traditional healers, mission hospitals, druggists and private pharmacists. With people's proven willingness to pay for health care, the aim is to provide them with what they need — a sympathetic and competent health worker and a reliable supply of the most essential medicines at prices they can afford.

Fourth, a community participation scheme. Communities assume responsibility for their own health care and services by participating in the management and financing of local health centres. This also serves to decentralize national resources. To start the process, international agencies help to train health workers and keep the health centres well stocked with generic drugs, bought in bulk at very low prices. Patients pay for services provided through a treatment fee, drug purchase, or in some cases, through prepayment schemes. Payment normally covers drug costs plus some local operating expenses, including incentives to the health workers. The revenues generated are managed by a committee consisting of members selected by the community. The committee is also responsible for identifying and ensuring treatment for those who cannot pay.

Today, over 20 million people in 26 African countries have access to affordable health care, because more than 200 districts are well on the way to revitalizing basic health services based on the Bamako Initiative.

Communities take part in managing and financing local health services, and improving the quality, accessibility and affordability of care and the availability of essential drugs.

The improvements have been confirmed by an outside evaluation. Three years after the Bamako Initiative was begun, the UK Overseas Development Administration, together with three other European government agencies, sponsored an independent evaluation by the London School of Hygiene and Tropical Medicine.

Case-studies from five countries implementing the Bamako Initiative — Burundi, Guinea, Kenya, Nigeria and Uganda — were reviewed to provide a better understanding of the Initiative's process, its successes to date and the emerging issues and problems.

The reviewers note that, although many problems persist, local communities are proving to be competent both in managing health care funds and in distributing essential drugs.

"The overall conclusion," says the London School evaluation, "is that much looks promising." It went on to recommend that UNICEF and other agencies continue to help implement and invest in the Bamako Initiative in each country.

Because of its successful start in Africa, the Initiative has attracted at least 12 other countries, including Peru in Latin America, and Myanmar, Nepal and Viet Nam in Asia, to explore the possibilities it offers.

And in Africa, where many sub-Saharan countries have had at least five years to make the Initiative a success, the goal is to quicken implementation to cover all the existing 40,000 peripheral health care units.

This goal was endorsed by the World Bank in its recent review of the health situation in Africa, entitled 'Better Health for Africa'. The review puts emphasis on community co-management as the key to reviving the continent's health system.

The Bamako Initiative takes root in five countries

The following case-studies provide a historical context to the state of national health care at the time the Bamako Initiative was first implemented. The studies include an independent assessment made in 1991 by the Health, Economics and Financing Programme of the Health Policy Unit, Department of Public Health and Policy of the London School of Hygiene and Tropical Medicine.

Burundi: Management training

The Bamako Initiative, begun in 1991, concentrates on improving care in health centres and encouraging better use of the facilities.

The focus has been on management training for health workers and health education services for the community.

Since the early 1980s, there have been user charges for health care in Burundi. In the prepayment system, health insurance cards cover primary health care and hospitalization. Payment can also be made directly for individual consultation and medication prescribed.

The revenue from the sale of health insurance cards is not as yet, however, retained directly by the community, and therefore it does not constitute community financing as defined by the Bamako Initiative. Because of this, the review points out that use of the system remained poor, as communities believed drug shortages still existed.

Community participation, nevertheless, has been ensured largely through management committees responsible for maintaining the health centres. Efforts are now being made to integrate the health insurance card system into the health care financing system of the Bamako Initiative.

Guinea: Comprehensive attempt

Following a national evaluation of Guinea's expanded programme on immunization (EPI) in 1986, the Ministry of Health made a comprehensive attempt to revitalize and strengthen its primary health care services.

The situation analysis and EPI coverage survey had identified extremely weak peripheral health services and very low EPI coverage of less than 5 per cent. With no funds available, health centres were virtually defunct. There was no petrol, no refrigeration units, no drugs or vaccines, and health workers went unpaid.

With the assistance of international agencies such as UNICEF, the Ministry of Health developed, for the first time, a programme to deliver primary health care services with community financing of recurrent costs through user fees.

In order to revitalize the existing health centres, the programme identified four areas for immediate attention and action: transport and distribution; training and counselling; follow-up and evaluation; and community participation and education.

Donor input into the programme in Guinea has been and still is considerable. UNICEF

provides a basic range of drugs for the first two years after the health centres have begun functioning, with community financing taking over the management of stocks of essential drugs. The community in many cases is also able to provide funds to pay for other maintenance and operational costs.

The independent assessment concludes from the five-country case-study comparison that Guinea has the most developed and most successful programme. It cites "dramatic improvements in the accessibility, utilization and coverage for basic health services."

However, there are questions about sustaining the activities in Guinea. The programme received substantial external funds, and some problems of community affordability have been identified. The process of decentralization is likely to experience difficulties as supervision, drug supply, maintenance of equipment and the monitoring system are all organized centrally.

Management and monitoring "were probably at their most advanced in Guinea," but the reviewers found areas for improvement.

Kenya: Community enthusiasm

When the Bamako Initiative was implemented in Kenya in 1989, there was an existing primary health care system with community health workers trained in preventive activities.

A national task force had identified the need to establish and maintain a supply of drugs to rural communities as well as increase community participation in health care.

The Bamako Initiative started off as a pilot project in Kisumu District, specifically to set up community pharmacies staffed by trained community health workers and managed by village health committees.

A limited list of basic drugs is supplied to the pharmacies through UNICEF. The health workers are responsible for administering the drugs, and a local supervisory committee monitors the sales.

According to the Initiative's principles, the sales of basic drugs should eventually generate enough money to buy and store replacement stocks, i.e. be self-financing. The pharmacies also sell low-cost mosquito nets impregnated with insecticide as part of the malaria control programme. This is very popular and subject to heavy demand.

Plans to phase out external support to the pharmacies and expand the programme to other areas are being developed.

The independent survey notes that Kenya has succeeded in generating community enthusiasm, which has led to a willingness and ability to pay community pharmacy prices.

However, the Initiative has not yet resolved such important problems as logistics, management, monitoring and supervision.

Nigeria: New elements

When the Bamako Initiative was introduced in Nigeria in 1989, there was an existing national primary health care programme partly financed through cost-recovery.

The Initiative reinforced existing activities but added new elements: community participation in revenue management, systems for monitoring and evaluation, and consultative committees.

The independent assessment notes evidence of increased use, and drugs available at affordable prices as a result of greater community involvement. The system required that part of the money generated from the sale of drugs be used for the purchase of replacement drug supplies.

However, the comparison study of affordability and patients' perceptions of health centre activities identified the problem of patients who lack the money to pay for health care. Increasingly, the communities themselves are taking responsibility for such cases.

Uganda: Cost-sharing

Although Uganda has not officially adopted the Bamako Initiative, it has applied its principles in developing national health care policies.

In the late 1980s, a system of community financing was introduced at health facilities with funds being retained and managed by locally selected health management committees.

Even after the cost-sharing policy was withdrawn in August 1990, some local health management committees continued their work in community financing activities.

The independent review points out that, of all the countries reviewed, Uganda faces some of the most difficult and entrenched problems of health service provision.

It also identifies two special problems in Uganda: a large, unregulated system of drug sales nationwide, and very poorly paid and motivated health workers.

In spite of the problems, it is significant that at least one district has made considerable progress in arranging health care based on community management and financing.

Summary

The successes achieved by the Bamako Initiative are not, according to the study, the result of community financing alone. Other essential elements include the specific historical context, a high level of political will, a substantial contribution of donor agencies in terms of financial and technical resources, the ability and willingness of the government to ensure the coordination of external support, the high level of commitment of Ministry of Health officials and the confidence of the people.

People of the Bamako Initiative

The Bamako Initiative is a way to organize health care with the active participation of concerned people at all levels — the mother who walks miles to the rural health centre; the government administrator who allocates funds to revitalizing rural health centres rather than to building more hospitals in affluent urban areas; the district health worker who is diligent about keeping medical records and following up with visits to people under her care — the list goes on.

In describing the Bamako Initiative in action, an important focus is the people who help make it work. The following documents their essential role.

National and local government: Active partnership

When the African Health Ministers came up with the innovative Bamako Initiative in 1987 to restore basic health services, they realized it was important to start with a partnership between government and local communities. The government provides the bare minimum of staff and physical facilities. Local communities are asked to become actively involved in the management and financing of their own health care.

This approach, originally developed for sub-Saharan Africa, where 26 countries have adopted it, has since been successfully adopted in Latin American and Asian countries, such as Peru and Viet Nam.

Local health centres run by the people are very much the driving force behind the strategy in Guinea, which represents one of the success stories of the Bamako Initiative at work.

"It is important for the community to participate," says Dr. Ousmane Banjoura, Secretary-General of the Ministry of Health of Guinea, "because the community itself knows best its own problems and its own needs. Thus, the community is able to orient the health team by saying: 'Here are the problems and the needs that we hope will be satisfied'."

Even before a community-focused health care strategy was developed as the Bamako Initiative, the Guinean Government had come up with a similar approach as its solution to a practically non-existent national health care service. An evaluation of the country's programmes for primary health care and immunization of children in April 1986 by the Ministry of Health (with UNICEF, the World Health Organization and other agencies) had identified extremely weak peripheral health services and very low immunization coverage (below 5 per cent).

With no money, health centres were virtually defunct. There was no petrol, no refrigeration units, no drugs or vaccines, and health workers went unpaid. Aware of the need to change all this, the Ministry of Health worked with UNICEF, WHO and other aid agencies to revitalize the health centres. They identified four areas for immediate attention and action: transport and distribution of essential drugs and medical supplies; training and counselling; follow-up and evaluation; and community participation and education.

Guinea is a poor country with little immediate hope of increasing its national health budget. In the capital city of Conakry, the national Government, however, is committed to working on an infrastructure that it hopes will become self-sustaining as local communities take over much of the management and financing.

The situation is somewhat similar in Nigeria. In Kaduna, a sprawling, predominantly rural state in northern Nigeria, the federal, state and local governments have used the Bamako Initiative to create a health infrastructure that has become a model for the rest of the country.

Nigeria had an existing national primary health care programme with cost-recovery based on revolving drug funds. But help was needed to involve the community in management. The Bamako Initiative added new elements of community participation in drug sales and revenue management, systems for monitoring and evaluation, and in setting up consultative committees.

The Local Government Council at Ikara in Kaduna state operates a central warehouse that stocks, sells and distributes essential drugs and medical supplies to four district stores in the area.

Mr. Sani, the Chief Health Officer of the Local Government Association, is not worried when the warehouse is sometimes nearly empty. "It is a good sign that the supplies have been sold and distributed to health care centres and village health workers," he explains to visitors.

The central warehouse started with an initial shipment of essential drugs from UNICEF valued at about 370,000 naira (US$18,500). With sales of these drugs to the district stores

in the area, there were sufficient funds to order replacement stocks from the main warehouse in Lagos, the federal capital. There was even enough to pay for a lorry to transport the supplies from Lagos to Ikara and, if necessary, to purchase supplementary drugs locally at market rates.

Ibrahim Hamza, the District Health Supervisor, is proud of the achievements in his district, including the availability of low-cost drugs on a regular basis. "We hope we have seen the last of the 'out of stock syndrome' that was normal in the past," he says.

Immunization against the six preventable childhood diseases is proceeding well towards the targeted coverage of 80 per cent of the children. According to Mr. Hamza, the Bamako Initiative has also been especially effective in helping to control the spread of malaria, by far the greatest health problem in the district.

The health centres are able to sell a dose of chloroquine for 2 naira (10 US cents), which is at least 10 times cheaper than at the local pharmacy. Now that the people are able to purchase drugs, they are not afraid to visit the clinics. "Lots of lives are being saved," Mr. Hamza says, "but it is important now to maintain our ability to meet this demand."

Kenya was also very much aware of the importance of community participation when it started implementing the Bamako Initiative approach in a cluster of villages near the town of Kisumu on Lake Victoria in September 1989. These first efforts focused on community management of essential drugs and basic health care services.

Dr. James Maneno, Kenya's first primary health care coordinator and current UNICEF Project Officer, observes: "For the last 10 years, the emphasis has changed. The emphasis has been on involving the people, the communities, in their own health care."

Dr. Maneno mentions the *harambee* spirit when he describes community involvement in Kenya. (*Harambee* in Swahili means 'let's pull together'.) He says: "We in Kenya are renowned for the *harambee* spirit — which was there even before independence — where communities have been able to build schools, start health centres, dispensaries and hospitals on a voluntary basis. And we have built our primary health care strategy on that *harambee* spirit."

Community involvement, as prescribed by the Bamako Initiative, starts off with making the local community responsible for its health units. Since the community is put in charge of finances, it has a commitment to make the system work. It knows that people will pay to visit the local health unit if they trust the staff and know there are enough medication and supplies at all times.

Community management committee: Retaining local control over resources

Wonkifong, a village 60 km from the Guinean capital of Conakry, was one of the first to revitalize its health centre under the guidelines of the Bamako Initiative. Its success illustrates the difference an effective management committee can make to the availability and affordability of essential drugs.

Ousmane Bayoma, the Chairman of the management committee, is happy with the early success of the centre and singles out the prices of drugs as an important factor. "People no longer have to go all the way to the pharmacy, and they can afford our prices much better," he explained.

Some countries had to adapt existing community financing mechanisms to meet

Bamako Initiative principles. Burundi, for example, has had a user charge for health care since the early 1980s. Payment could either be in the form of cash, for consultation and medication, or by health insurance cards, a prepayment system covering primary health care and hospitalization. Since the revenue from the sale of health insurance cards was not retained by the community, the financing system did not follow the Initiative's principles of local control of resources generated. Efforts are currently being made to integrate the health insurance and fee card systems into the health care financing system of the Bamako Initiative.

Health workers: Training and outreach

In the Bamako Initiative approach, health workers serve as front-line caregivers who have to be sympathetic and competent. They look after the people who come to the health centres and they visit outlying villages. In many cases, they are bringing formal health care to remote areas for the first time. In revitalizing health centres by using the principles of the Bamako Initiative, the Guinean Government included retraining of their health workers. They are encouraged to be more responsive to their patients. They meet regularly with a village health committee to decide on priorities and policies. The committee and the health workers make decisions jointly.

Hawa Binta Diallo, Director and nurse at the Ditinn health centre, has a staff of four to help her provide prenatal care, maternal and child immunization, and consultations, and administer care in health emergencies for the local population. The centre serves 10,000 people in Ditinn and eight neighbouring villages.

Ms. Hawa has worked at the health centre for 11 years, and she has seen major changes in that time. She used to be one of two workers and rarely had enough medicines and supplies. Now the new centre built by the community has a kerosene refrigerator and a regular source of essential drugs and supplies.

"The training courses organized in 1988 by the Ministry of Health with support from UNICEF have helped me manage my new responsibilities," she explains. Besides treating patients, prescribing medication and educating them on personal hygiene and preventive medicine, she maintains records of all patients, their ailments and prescriptions in order to keep track of the centre's stock of medicines and supplies.

Ms. Hawa is grateful for her motorcycle, which has given her greater mobility in her outreach services. She is able to make house calls and also visit the nearby village of Kamakoro on the weekly market day, when villagers come to town with their children. That is when Ms. Hawa and her staff conduct vaccinations at the village school next to the market.

Looking for practical solutions to problems is one responsibility of the health worker, especially one who is the Director of the health centre.

At a small health centre in Kalente, the Director is summoned by the management committee. The centre had started a child immunization programme. Considerable effort had gone into tracing the mothers of children, even those living in remote areas. This dose of vaccine had been given to 70 children in all.

Initially, the Director had proudly presented demographics of the children, how they were traced, how long it took to do so and whether the children were healthy when they were vaccinated.

But then something went wrong. Of the 70 children vaccinated, fewer than half returned for their next injections. When he was asked about this figure, the director was unable to provide any answers.

The committee chairman then reminded him: "Your job is to convince the mothers that the vaccine cannot work unless the entire series is given. You have obviously not carried out your job sufficiently well as the mothers have failed to return. Convincing the mothers is as important as vaccinating the children."

The health centre staff and management committee members then launched into a long discussion. They finally agreed on a solution. On market day, they would set up a temporary stand to administer and record the next in the series of vaccinations. Then the staff would look for the errant mothers when they came with their children, and ask the mothers whether their children had returned for the second vaccination. If not, they would bring the mother and child to the nearby stand.

Community health workers: Constant contact with people

The community health worker, often a volunteer in charge of a number of households, also plays an enterprising role whenever there is an opportunity. In the Kisumu district of Kenya, malaria is a major problem. Nearly one third of all infant deaths and almost one half of adult deaths are attributed to the disease. To combat this, the Disease Vector Control Board has worked out a malaria control programme as part of the Bamako Initiative action plan. Mosquito nets are dipped in insecticide and sold to villagers through health clinics staffed by community health workers.

The community health worker talks to the villagers and educates them about the need for and use of mosquito nets. Rosa Banja is a community health worker in the Katolo East sub-location of Goo Ramogi area. She is a volunteer and, rather than being paid a fixed amount for her work, she receives a cash incentive for managing the sales of medicines and mosquito nets at the health clinic.

"We have saved a lot of money — from the drugs plus the nets, we have 310,000 Kenyan shillings (US$5,000) in the Bank of Kenya Commercial," discloses Ms. Banja as she displays the detailed accounting to keep track of medicines and nets sold, to whom and for how much money.

She adds: "With the money — you know, in time UNICEF will leave us — we want this, our project to go on. We don't want it to collapse. That's why we are keeping this money."

When the Bamako Initiative was implemented in Kenya in 1989, a primary health care system already existed, with community health workers trained in preventive activities.

A national task force had identified the need to establish and maintain a supply of drugs to rural communities as well as increase community participation in health care.

The community: Trust and confidence

The Bamako Initiative helps countries to organize basic health care for the poorer, scattered, large rural population. And for it to succeed, the people must choose to use their local health unit. And they do.

"More children are healthy now, there are fewer epidemics, and treatment is more readily available." Fatumata Diara Diallo, an elementary school teacher and mother of five, says of the improved health situation in Ditinn (Guinea). She lives about two miles from the health centre and uses it frequently.

"I have seen the difference between going through pregnancy with iron pills and without," says Aminata Diallo, a mother of seven who is thankful for the prenatal care at the health centre. She adds: "Now I am more relaxed during my pregnancies and I have more energy and strength."

Fatumata Rabi Balde used to live in a remote area where health care was not available and her husband had to take her and the children to town on his motorcycle for vaccinations. She used traditional medicines whenever she fell ill. But now that she has moved near the Ley Sare health centre in Labe, she visits the centre whenever she is ill. "I can get well faster," she adds.

Adama Barry Diallo, a mother of eight who visits the Ley Sare health centre regularly, supplements the medicines bought from the centre with traditional cures she grew up with.

During the rainy season, when all her children fall sick, usually with malaria, she admits: "I treat them with cassia as well as with the pills I get from the centre." The leaves of the cassia plant are believed to contain quinine.

In Guinea, Senegal and most African, Asian and Latin American countries, women take charge of their family's health. The Bamako Initiative helps them to do this with educational efforts through health workers and women's groups.

"Women are concerned with health care, because if your children aren't healthy you can't perform any of your duties. You can't cook or do any other work," says Mrs. Ly Aissasitou Ba, president of a 700-strong women's association in Galoya village in Senegal.

Like most of the other women in the village, Mrs. Ly is married, has children and does all the housework including carrying water from the village well. Mrs. Ly describes the association's activities, which are primarily focused on health issues: "Every time we meet, we talk about women bringing their children to the dispensary to vaccinate them. If women do that, it will help reduce their children's sickness. Many people didn't know that before we talked to them. So we're educating them." The outreach to women is part of the Bamako Initiative strategy to educate and make villagers aware of the need for basic health services.

Martin Murama, UNICEF Logistics Officer in Senegal, explains: "The Bamako Initiative concerns the totality of the health problems of the population. They need to be informed about family planning, malaria, diarrhoeal diseases and so on. To whom should one speak? To the women! Grouped together — not house to house. Women are the key."

One way in which the Galoya Women's Association communicates with their members is by producing local plays with stories about health care. Even the actors share the concern and are involved in getting the message across.

"We have to put in our minds the inform ation that the health workers bring us; we have to involve ourselves and not just wait for others or for God to help us," explains one actor, playing the part of a stubborn husband who refuses to take pills to prevent malaria, because, he claims, his ancestors lived for 500 years and never got the disease!

Compiled from reports by the Finnish Committee for UNICEF and freelance writers Laura Lorenz Hess and Julia Spry-Leverton.

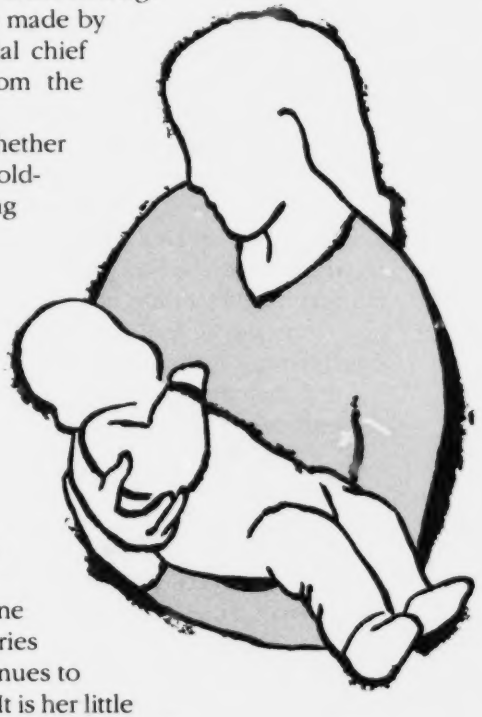
Little miracles in Benin

by Alegria R. Mendoza

It is late afternoon at the health centre in Djougou in northern Benin. Things have calmed down after a long and busy day, with villagers coming in from the surrounding area for medical attention and essential drugs.

Isso Halidou, the nurse in charge of the centre, is still busy in his office, surrounded by files. He is being queried by a team of three supervisors from Parakou, the capital of the neighbouring province of Borgou.

An interesting and unusual feature of the Bamako Initiative in Benin is interprovincial supervision. Facilitating the exchange of expertise among national, provincial and other officials, inspection visits are made by a team consisting of the national supervisor, the provincial chief doctor and director of health and the chief doctor from the neighbouring province.



Team members are relentless. They want to know whether the supply of essential drugs is running low, whether the cold-chain equipment used to keep vaccines viable is functioning efficiently, what type of training the nurse and his assistant require, and whether accounting records are in order.

Mr. Halidou refers to his accounting books to answer a question about the monthly maintenance cost for the health centre. As he quickly adds the figures in the columns, he hears his assistant cleaning up in the next room. The supervisors from Parakou pause in their discussion about the next item to examine.

All of a sudden, the silence is broken by piercing cries of despair and lamentation some distance away. A woman is running desperately to the centre carrying a bundle wrapped in what looks like rags.

As Mr. Halidou hurries to the door, followed by everyone else in the centre, the young woman rushes up to him. She tries to speak even as she attempts to catch her breath and continues to sob uncontrollably. She hands over the bundle to the nurse. It is her little boy Ahmad, with his head hanging back, eyes rolled over and feverish body racked with convulsions.

"*Doto, doto* (doctor, doctor), my child, he's dead, he's dead ..." cries the woman, whose surname is Assiatou.

Her cries are echoed by a group of villagers including Ahmad's grandmother, who follow Ms. Assiatou into the centre. They are friends, relatives and curious bystanders who want to find out what will happen to the dead child.

Mr. Halidou calmly asks: "When did the baby fall ill?"

"About three or four days ago. His body was hot," Ms. Assiatou responds.

"And what did you give him?" Mr. Halidou continues his inquiry.

"I gave him boiled leaves to drink," the mother informs the nurse.

"Since he did not get better, why did you not bring him here sooner?" Mr. Halidou asks.

"I did not have any money," the mother replies, "but since it is quite serious now I had no choice."

"I would like to look at his vaccination card," Mr. Halidou tells the mother. Even in an emergency, he uses the opportunity to check whether the child has had all the required shots. Ms. Assiatou turns to her mother, asking her to fetch the card from home.

As he speaks, Mr. Halidou undresses the boy and carries him to his small clinic. He takes the clothing and soaks it in cold water from a nearby well. He wraps the baby in the clothing for five minutes, and then wrings out the water before soaking it in fresh cold water again.

He repeats this procedure three or four times. After he has determined that the child's body has cooled down sufficiently, he gives him an injection for what is clearly a malaria attack. Slowly, the infant comes back to life, his body temperature lowers, and his breathing becomes normal.

Around them, tense faces relax, and the mother, Ms. Assiatou, cries out: "A miracle, a miracle!" Everyone is amazed that wrapping a feverish body in wet clothing can lower a fever.

"How much does it cost?" Ms. Assiatou asks. Mr. Halidou replies: "The charges are 100 CFA." Ms. Assiatou is quite surprised that the cost is so low, equivalent to 35 US cents. And the villagers around her look at each other with similar amazement. They appear to be convinced that the health centre actually works.

One of the supervisors from Parakou is also impressed. "You have learned a lot, Halidou," he says. "We have been hearing good things about you." Mr. Halidou is reminded that the complicated cases he is unable to handle should be referred to the health centre, only two km away.

Mr. Halidou feels good about his work. He remembers that not too long ago, he was tempted, like so many others before him, to ask for a transfer to the capital city of Cotonou. At that time, no one visited the centre because no one had faith in him. The clinic had no drugs and he could not offer much to the people of the commune. But since then things have changed, especially through his efforts to educate as well as provide health care services for the surrounding villages.

For Ms. Assiatou, the experience has been a close call, and she is grateful that Mr. Halidou has been able to save her son. Then she thinks about the recent conversation she had with a member of the *comité de gestion communale* (communal management committee). She had been asked to join the Committee but declined because it would mean more work for her. She had not been sure about the benefits of the health centre to herself and her family. She had visited the centre with her son but still used traditional medicines when her son was sick and she had no money.

Now that things have changed so dramatically, Ms. Assiatou thinks it is time to help the health centre. She decides that she will definitely join the management committee. She will take turns with the other women to help clean the centre. And she will even ask the other villagers to help Mr. Halidou clear his land since the nurse cannot work at the health

centre and still have time to farm his land. She plans to talk to the other members that same afternoon.

Ms. Assiatou's story is typical of many others who have managed to overcome ignorance and distrust and now participate actively in managing their own health care services.

The Djougou centre is one of 366 health centres in Benin which provide 90 per cent of the country with primary health care under the Bamako Initiative. UNICEF, along with the World Bank and various European agencies, provided funds for the initial stock of essential drugs for the central warehouse in Cotonou.

The purchase and distribution of essential drugs is now self-sustaining, funded through the sales receipts from all the communal and sub-prefectural health centres. All these centres, including the commune in Djougou, have management committees that participate in supervision, monitoring and financial management.

In the Djougou centre, the money collected from patients is used to replenish the stock of essential drugs and to run the centre, such as paying for the furniture, gas, local salaries and instalments on the refrigerator and the motorcycle that Mr. Halidou uses. The Bamako Initiative is working out well in Djougou.

Alegria R. Mendoza is the UNICEF Representative in UNICEF Cotonou, Benin.

Nepal tries community health insurance

by Kedar Nath Sharma and Om Khadka

Chandrika Limbu has been ill for a month. She complains of stomach-ache and indigestion. And for the past three days, she has had blood in her stool. Her father, Santa Bahadur, consulted the *dhami* or traditional healer of their village.

The *dhami* diagnosed Chandrika as suffering from *nash*, an ailment known only to him. And he recommended that the cure should be the slaughter of a black cockerel.

Chandrika's father had no choice but to follow the instructions. He selected the cockerel from his own pen, one which he had intended to sell at the local market for 200 rupees (US$4). He did this after he heard the *dhami* assure Chandrika that she would be well the day after the black cockerel was killed. But her condition did not improve the next day, or even the following week.

Finally, Mr. Bahadur decided to go to the Sulubung health post, some distance from Maipatal, their village in eastern Nepal. There, the health assistant gave Chandrika some painkillers and prescribed medication for her ailment. However, the girl and her father were not able to buy the drugs at the health post or at the local pharmacy. Mr. Bahadur had to walk for four hours to the district headquarters in Ilam Bazaar, where he hoped to buy the medication.

The shortage of essential drugs in rural Nepal creates serious problems for poor, illiterate villagers. Often they have to walk long distances to towns to buy drugs usually sold at inflated prices. And when the retailers run out of medicines, they persuade the desperate villagers to buy useless substitutes and vitamin syrups.

Geeta Parasad Niraula, who manages the Sulubung health post, is concerned about sending his patients out to buy the prescribed drugs. The budget allocated for purchase of essential drugs only lasts them for three months. "There is no way out but to suggest to patients that they buy medicines outside," he adds.

Mr. Niraula and his staff had once tried to operate a private retail pharmacy for the patients. But they were forced to close the shop after they were accused of selling medical supplies from the health post.

Even though the villagers are poor, they do not hesitate to pay for health care. They have been known to spend money on goats, cockerels and fees for traditional healers.

"Though the patients and their guardians are ready to pay, we are unable to provide them with medicines at the right price and at the right time," said Mr. Niraula.

Dhana Bahadur Rai, another patient at Sulubung health post, sums up the health care priorities of rural Nepal: "We may not need a big hospital if we can get the medication at the health post where it is prescribed."

Nepal is a land-locked country sharing its northern border with China and the rest with India. The open borders with India result in an unrestricted flow of medical supplies from that country. Unfortunately, legislation, such as the Essential Drug Act, has not been

enforced in Nepal, and this has made the country a dumping ground for drugs from India.

"A very large number of pharmaceutical products dumped by the Indians are useless and substandard. It is the attractive commissions and gifts offered by the manufacturers that make medical retailers push the sale of these useless drugs," explains Dr. Prem Thapa, who works at Pokhara Regional Hospital.

In looking for solutions to this problem, one health facility in Chapagaun village, about 12 km south of the capital of Kathmandu, recently adopted a medical insurance scheme that provides funds for health care services, especially essential drugs.

"The main objective of this scheme is to mobilize the limited resources of the health post, to provide better services to the public and to make it a self-sustaining operation," says Krishna Hari Paudyal, the health officer in charge of the Chapagaun Teaching Health Post.

Established 10 years ago by the Christian United Mission to Nepal, the health post receives 25,000 rupees (US$500) every year from the Mission, which covers a quarter of the expenditure on medical supplies and essential drugs.

To cover the rest of the expenses, the health post charges a premium of 50 rupees (US$1) per household annually and 3 rupees (6 US cents) per visit. And there also is a nominal charge for prescribed medication.

Gopi Nath Ojha, a farmer, recently visited the health post for medical treatment. He is satisfied with the services, pointing out: "Before, we had to go to Patan or Kathmandu just to buy some pills for headaches. Nowadays we can get essential drugs from the health post."

Mr. Ojha's family is one of 1,200 households in the Chapagaun area that benefit from the services and medical insurance scheme provided by the health post.

Man Kumari, a villager who visits the health post for treatment of her four-year-old daughter, notes: "At first we considered the premium to be high, but now it seems nominal when we calculate the cost involved in going to the cities even for minor ailments."

The funds collected from the household premium and prescription charges are managed by the village health committee. The committee decides on such matters as premium charges and the purchase and distribution of essential drugs and medical supplies.

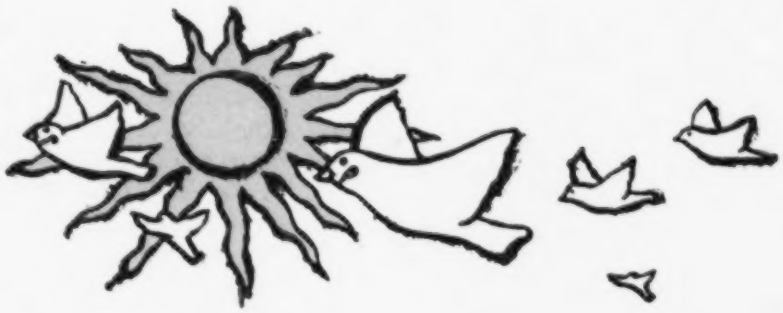
There are 11 other such programmes being implemented in different parts of the country. With objectives and guidelines similar to those of the Bamako Initiative, these schemes are designed to provide essential drugs at affordable rates and discourage their incorrect use.

The Ministry of Health is involved in these efforts to make the supply of medicines practical and rational. And participating health posts are aware that external coordination and grants are necessary for such cost-recovery programmes, at least in the pilot phase.

Kedar Nath Sharma and Om Khadka are freelance journalists based in Kathmandu.

Health care in coastal Guinea

by Laura Lorenz Hess



The road to Tanene lies north of the long peninsula of Conakry, along Guinea's coastal region, lined with low, ridged hills. Along the road are palm trees with colonies of nests, woven by weaver birds, hanging on the lower branches. The small, yellow birds flit from tree to tree in chattering groups.

The Tanene health centre is one of the first established in Guinea under the guidelines of the Bamako Initiative, on 15 November 1988.

It is a very hot, humid day in mid-May. Saliou Bailo Diallo, Director of the centre, is tending a patient, an older woman who has come from 20 km away. Several patients wait outside, where they can hear the sounds of children playing in the school yard nearby.

The centre provides primary health services for almost 17,000 people, mostly farmers and fishermen living in the surrounding coastal area. Demand for primary health services is high in this area: The health workers see about 30 patients a day and immunize an average of 62 children every month. The impressive figures provided by Mr. Diallo are the results of an efficient monitoring system set up and maintained at the centre.

The centre and prefectural health ministry staff fill charts together every six months to monitor health care delivery at the centre.

"The monitoring activities help us think about what we have done well, what we have not done well and why," says Mr. Diallo, who proudly points to the 96 per cent immunization coverage for the children served by his centre. "They also help us to understand what actions we must take to improve."

When the centre first opened, the staff wondered why mothers failed to bring their children for vaccinations. Before that, the Government had organized rural campaigns for free immunization in certain areas. But the immunization coverage in the areas served by the health centre was very low. Mothers, the health workers discovered, were concerned about the slight fever a child might run after being vaccinated. And they did not know what the vaccination was for. The staff organized an education campaign. "We had to explain to mothers the importance of immunization," says Mr. Diallo. "Now that they understand, it is the mothers themselves who approach the centre or our outposts." And this is done even though they know they have to pay for vaccination cards.

The management committee members of the Tanene health centre also participated in the campaign. They visited local community centres, mosques and markets to tell people when they should bring their children to be vaccinated. "The technical staff can't do the

work we have to do and also go out to inform people if they haven't come in," says Mr. Diallo. "Our centre's success comes from the technical staff and the management committee sharing the work."

Naby Sylla is the treasurer of the centre. He collects the money that the centre receives every day for treatment and medicines, and makes a monthly deposit at the bank in Fria, about 60 km away. His credibility in the community gives people confidence that when they pay for services, their money goes to support their health centre.

"At first it was difficult to convince people that they had to pay for services," says Mr. Sylla. "We had to explain to them to make them understand. Now everyone knows that the medications are effective and they cost a lot less at the centre than they do in the market."

The cost for medication for malaria, for example, is about 60 US cents for an adult and 30 US cents for a child for a three-day treatment of chloroquine and aspirin. Parasite medicine costs the same. A vaccination card costs about five cents. Prenatal care costs about 50 US cents.

The centre is very strict about charging everyone. No one gets free services. "Most people have family or somebody who will pay even if they don't have the money themselves," says Mr. Sylla. "If, for some reason, they don't have any money, I might even take money from my pocket to pay for them, but we never say that they don't have to pay. Otherwise, nobody would have money the day they needed to come to the centre."

Since 1990, the centre has operated with a small surplus. There is money to buy medicines and supplies before stocks run out, and there is money for maintenance, such as a fresh coat of paint and a new mat ceiling.

When the centre was first established, it provided services for all those who came. "It was difficult to treat sick people and do vaccinations for the whole sub-prefecture here at the centre," says Mr. Diallo. They then decided that higher immunization coverage could be achieved by sending the centre's vaccinators out to all the 14 sub-prefectural districts. The workers have been travelling by motorcycle on a regular monthly schedule since 1989.

The success of this outreach effort has prompted the director and the management committee to expand outreach services to cover all primary health care services. Recently, a pilot effort was organized with the setting up of a health post in Dembay, a district capital 30 km away. The health post is staffed with one health agent who provides consultations as well as medicine. Mr. Diallo visits the Dembay health post every two weeks to check its stock of medications and supplies and to consult with the health agent and the two management committee members.

"Eventually, we would like to establish a health post in five of the districts in this sub-prefecture," says Mr. Diallo.

Many different factors have contributed to the success of the centre: good management, a credible management committee, respect for the health care provided, and the desire of the staff to constantly improve their services. The proof of that success is in the steadily growing demand for services.

"Now, when people get sick, they come to the centre instead of waiting," says Mr. Diallo. "Before, they waited until they were very ill before they came. But it is not often we have cases like that now. Now they understand, and they come."

Laura Lorenz Hess is a freelance writer, based, until recently, in Guinea.

Hope becomes reality in a Mauritanian village

by Mohamed Abdallahi Bazeid

Never before has Mariem seen so many children in Lemden village, in rural Mauritania. The children sit beside her, under the shade of the acacia tree. They are laughing and pushing each other, their little faces glowing with health and happiness. When Mariem left the village six years ago, these children were not yet born. Besides, at that time few children survived the annual epidemics of measles, whooping cough and other illnesses.

"Since we opened the community health centre, the health situation has improved considerably," her cousin Leila told her.

"That's certainly true," added her aunt Aicha. "Whenever we fall ill we go to the community health worker for an examination, and usually we get effective treatment for a modest sum. Last week, I was treated for a fever and headache, and it cost 60 ouguiyas (50 US cents). Next to nothing."

In the week since she returned to Lemden for the school holidays, Mariem has heard all the women talk about the new community health centre.

Teslam, a friend of her mother's, told her that admissions to the local dispensary had become rare and childhood diarrhoea is no longer a problem. "We can treat it at home with a drink made from water, salt and sugar. We no longer have to sell a sheep to pay for a prescription. And we can buy drugs at a very reasonable price in the village," explains Teslam.

According to Amina, Mariem's childhood friend, things have changed a lot. "Families no longer hide their children when they hear that a vaccination team is coming. Instead, they bring them to the nurses as soon as the team arrives. All the women now know from experience that a child who is not vaccinated is running a very serious risk."

"If he contracts an illness he can contaminate healthy children, and that we do not accept," adds her husband.

For Hindou, the village's renowned weaver, Lemdem has been transformed. "You can see for yourself, Mariem, that the village is very clean. People no longer throw their household waste and used water all over the place. That practice is now banned. As you have no doubt noticed, the women take much more care over their children's personal hygiene and their clothing. This is new, and I am delighted to see it. I, whom your mother used to call 'Hindou Disarray', no longer tolerate the least speck of dirt in my yard or in my house. Since I started to attend the talks organized by the community health worker, I can see that dirt can be deadly to my family."

Mariem has only to look at the evidence to see for herself that Lemden has changed for the better. In just five years, the people have come together to take control over their own health problems. And they have succeeded.

The health council, with members elected by the villagers, has been managing the funds generated from the community health centre, according to principles of the Bamako Initiative. The council will soon be ready to finance the construction of a new classroom and the extension of the mini-network of water pipes for Lemden. "It is a very good practice to recoup our medical costs," the school principal tells Mariem. "The profits earned last year paid for 50 desks and a lot of school supplies."

Mariem encounters the same enthusiasm with Aunt Fatimatou, the traditional midwife of Lemden. "All the equipment you see here was bought out of the profits earned last year," she says. The equipment of which Fatimatou is so proud includes a birthing table, some packets of gloves, a pair of scissors, a number of compresses, a box of soap and three bottles of an antiseptic, Mercurochrome. Aunt Fatimatou is also proud of the general health and well-being of the children in the village. She and the community health worker have managed to teach the women to use local produce to prepare nourishing gruel for their children. Mariem now understands why the children she sees every day look so well fed.

"You know," explains Malika, the Lemden community health worker, "in terms of health, we have achieved a great deal. I realize that UNICEF continues to monitor what we are doing, to facilitate the supply of essential drugs and to provide training for me and the traditional midwife. But, while this is perfectly true, we are basically the ones managing our own health problems. With or without UNICEF we are determined to continue this Initiative."

Mohamed Abdallahi Bazeid is a reporter with Rural Radio of Mauritania, based in Nouakchott.

Mamadou

by Joel Breman

Mamadou is a fictitious boy, but his story and the story of his family and his community is real enough, not only for West Africa where it takes place, but also across much of Africa and other parts of the developing world. Life in his village, though seemingly mundane with its cycle of ploughing, planting and reaping, really hangs on a slender thread. Illness, which could occur at any time given the lack of knowledge, opportunity and means of prevention and treatment, frequently throws entire families into desperation and despair.

Poverty and powerlessness combine often to snuff out young lives, until one day the community learns of a way to help itself — by getting involved in setting up and running its own primary health service, buying its own essential drugs, choosing its own volunteer health worker, keeping records and accounting for payments collected, learning how to prevent disease and to maintain good health.

The principle and practice of the Bamako Initiative — health care and essential drugs supply through community support and participation — is gradually reaching villages like Mamadou's, allowing people to help themselves and fulfilling the promise of the slogan 'Health for All'.

The story of Mamadou is written by Dr. Joel Breman, an epidemiologist with the US Centers for Disease Control and Prevention (CDC) who lived in West Africa in the 1960s and 1970s, working in programmes supported by the US Agency for International Development (USAID). Until his appointment in October 1993 as Associate Director for Operations, National Vaccine Program, Office of the Assistant Secretary for Health, US Department of Health and Human Services, Dr. Breman was the Deputy Chief, Malaria Branch, Division of Parasitic Diseases, National Center for Infectious Diseases, CDC. He is also a frequent consultant for the World Health Organization.

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"Therefore was a single human being created: To teach you that to destroy a single human soul is equivalent to destroying an entire world; and that to sustain a single human soul is equivalent to sustaining an entire world. And a single human being was created to keep peace among human beings, that no one might say to another: My lineage is greater than yours!" — Mishnah, the oldest authoritative post-Biblical collection and codification of Jewish oral laws.

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Mamadou is unbearably hot and thirsty. He has been helping his father and older brother all day in the cassava fields. The plants are very high. It is time to go down to the roots and get that big, gnarled, firm shoot — uproot it, shake off the clay and mud, stack it with the

other shoots to carry home and then to the market. His mother will do the rest. But he has great trouble now bending over. Since awakening he has had a dull ache behind his eyes and a depleting weakness. He could only eat a half a bowl of *lait caillé* prepared by his mother — and he drank several gourds full of water, for he was sweating when he awoke.

Five-year-old Mamadou is the youngest field worker on this day. He is quite quick mentally and shows unusual coordination on the soccer field — reasons why the men allow him to work with them on the farm well before the other boys his age. Since April, when he walked to the fields at daybreak, he had been carrying three or four of the *coupes-coupes* on his shoulder, but today he gave them to Oumar, his older brother. Today, within 30 minutes of their departure from the village in the cool of the morning, Mamadou was too weak to carry the covered bowls with the millet cake and gumbo sauce securely on his head. And he was thirsty again.

Throughout the morning Mamadou stayed in a shady area, sitting and watching the others. Towards mid-morning the pulsing headache faded somewhat, and he was able to pull and clean a few roots. He drank some more and then went to get the roots collected by his father, two uncles and brother, who were bent over in the field, working intently with their hoes on the small ancestral farm. The stack of roots was tied into bundles of eight or more, the number depending on the size of the carrier. After the others ate and went back to work, Mamadou was again sitting in the shade — exhausted, without an appetite. His father said to sit and wait, but Mamadou was sick and humiliated, for it was the first time he had come to help the men with the harvest. Perhaps if he just had something to eat. He took a chunk of *tob*, dipped it into the gumbo, gulped it down, then took another lump. Not very easy to swallow — but he could work with his father if he felt better. Within minutes after swallowing he felt light-headed, with a rolling sickness in his belly. The headache was back. Mamadou rose unsteadily, and his vomit splattered over the stack of roots as he stumbled towards the fields.

Return to the village

Kassamba, Mamadou's father, had seen his son's distress and came to a decision quickly, even though the yearly harvest needed all of the able bodies in the family; this need had brought young Mamadou to the fields even though he had felt unwell on awakening. Now, Oumar would have to take Mamadou home, and the men would join them at night. The boys left the fields and headed home with the sun overhead. It took three hours to return to the village. Mamadou had to rest often along the way. The first two thirds of the journey he felt better — but later, a deep shivering chill began rumbling up his spine, and he began sweating as the sun moved across the denuded corn fields of the village cooperative farm.

Binta was beating harvest grain into powder with a few women for the evening meal when she suddenly looked to the west, into the sun. She knew something was wrong immediately when the silhouette of her two boys appeared on the ridge at the edge of the village. She put the pestle down and watched as they crossed the tattered corn fields. Mamadou's head was down, and he was moving slowly behind Oumar. With lowered eyes he told his mother what had happened, the hot body, the weakness and vomiting — the headache and shivering. Binta looked into her son's sunken eyes. His skin was very warm, and he was uncharacteristically stoic.

Binta had reservations about seeking help from the traditional healer in the village, as she had seen the poor results achieved with many of the treatments he used. Yet her parents and grandparents had faith in the local *guérisseur*, and they had paid many chickens, goats and francs to healers over the years. Friends and neighbours visited the village healer frequently, especially for cures for infertility, impotence, snakebites — and fever. There was often no one else to consult in the village. It was what was always done, it was the tradition. So Binta called on old Sidimé, man of powders, herbs and small skulls.

Sidimé was certainly strange, but respected. His incantations were thought by the villagers to have put an end to the ravages of the measles epidemic that began in January, and finally ended in June, leaving 10 very young children dead in their own village.

Sidimé saw immediately that this was fever and weakness in a young boy and asked the mother only one question. "Had she or the boy transgressed against the ancestral spirits?" "No," replied Binta, deferentially. The fire was lighted with special twigs; the grey ashes were prepared, mixed with the leaves of the nyere tree, and put into a small soot-blackened pot of boiling liquid. It was almost dark, and Mamadou couldn't keep his eyes open, he was so tired — too tired to be frightened by the spectacle. Sidimé brought the tea to Mamadou while his mother helped him to sit up. She opened his mouth and slowly poured the infusion into it. The taste was bitter, sandy and metallic — only a couple of spoonfuls entered. He lay down, dizzy. A short while later, returning to his compound, Mamadou belched and vomited again, temporarily getting some relief. But the aching behind his eyes continued.

When his father opened the door to the hut, Mamadou could see the flame leaping in the courtyard of the compound. The sky was black, and thunder was rolling in the distance. Kassamba put his hand on Mamadou's forehead and said, "The fever, very bad fever." He heard of the visit to Sidimé and told Binta that they must go to the clinic at Yalosemba, 25 km away. To be there in the morning when it opened they would have to leave very early. Mamadou became very cold; the blanket and mother's cloth wrap were inadequate to prevent him from shivering again, and he was drenched. He had not urinated since the morning. While Kassamba was eating Binta admitted to herself fearfully that Sidimé's treatment had failed. She hastened around their two-room mud hut gathering a few items for the walk in the morning.

Journey to the clinic

Neither parent could sleep, for they had seen the fever extinguish the lives of many young children in the village, despite the ministrations of Sidimé. While the fever was accepted as inevitable, the loss of their child was not accepted by Binta and Kassamba. The moon was full when Oumar was left with their neighbours, the Traorés — just as young Daouda Traoré had been left with Mamadou's parents last July when the Traorés had gone to the clinic with their feverish daughter, Fatoumata. Binta shivered upon recalling that Fatoumata returned from that hospital visit wrapped in a shroud for burial.

To move faster, Mamadou was secured on his father's back. They began walking briskly on the side of the path, now deeply rutted from the heavy summer rains. They knew this route well. It took them to the market, to the school, to the farmer's cooperative, to the maternity clinic where Oumar and Mamadou and some of their nieces and nephews were born. Kassamba, now 33 years old, was also born in Yalosemba, but he was delivered on

the mud floor in his grandmother's hut with the assistance of the traditional midwife. The visits to Yalosemba clinic brought either life or death, he thought. Even with life, lately, many of the newborns seemed to die within a few months.

Binta, Kassamba and Mamadou passed the crumbling mud walls of the last family compound in the village, and headed towards the dispensary, under the moon. From the distance, lightning and thunder came to them, but the expected battering sheet of rain moved over them quickly while they waited under protective banana trees. Kassamba began to speed up the pace after an hour, even though they were now walking in mud. He felt the inertness of Mamadou on his back. Later, while adjusting the cloth more securely around his waist, the burning slab between Kassamba's shoulder-blades began to shake uncontrollably, his head snapping backwards. They stopped, unwrapped the cloth and laid Mamadou on the grass at the side of the path. Was Mamadou dying? Was this the end? Binta began to cry as father kept the boy from bruising himself on the ground.

In a few minutes, the shaking stopped and she offered some water to her son. She wiped Mamadou's face and chest where the sweat had pooled. His arms and hands felt cool.

Binta knew that the child had *eba* — the malarial fever — and regretted that she had forgotten to bring the two pills for malaria kept in the house — the ones that remained after the incomplete treatment given to Oumar for *eba* two months before. But Oumar was seven years old. He could eat and drink when he was sick and did not shake and stare blankly like Mamadou. Oumar was able to help his father in the fields within a week after taking the tablets that Binta had bought from a woman merchant at the weekly market in San. Binta recalled that she had missed a meeting of the newly formed women's cooperative while caring for Oumar the day after he became ill; she was told that the women talked of their children's health at the meeting and of the importance of keeping medicines for fever at home. Binta knew that Mamadou's illness was much more serious than Oumar's had been, and she needed the fever pills desperately.

After a short wait, the parents saw Mamadou stir and begin to whimper — a good sign, for they were expecting the worst while he was convulsing. They were beginning to feel completely helpless. While childhood death was a frequent event in the villages, they knew that it was not inevitable, that the hospital in Yalosemba had something for sickness that was lacking in their villages — doctors and drugs. His mother put the boy on her back snugly, wrapping his buttocks and back with the *pagne* and securing it around her body; she placed another cloth over his shoulders and head, tying this one loosely to the tuck of the *pagne* at her waist.

They set out again onto the path, illuminated by the cloud-shrouded moon and accompanied by the rubbings of the cicadas and other sounds of the savannah. Every so often the boy muttered his mother's name; they would then stop momentarily to give him some water, which he sipped sparingly. Mamadou would sink off again, bouncing limply on his mother's back. In a few hours, they moved past the experimental farm station. A short while later, they saw the flickering lights of kerosene lanterns in the distance and knew they were on the outskirts of Yalosemba. They went immediately to the clinic.

Already, there were several persons huddled under the huge baobab tree, 30 yards from the entry into the stucco building, dark grey in the haze of dawn. Those clustered were young children with mothers, grandmothers and aunts. Except for an occasional cough, the group was surprisingly quiet, thought the father. As the first light broke, Mamadou's parents

saw that several children were shivering, and others were breathing rapidly. Everyone was passively awaiting the doctor's arrival. Binta asked the night watchman where the doctor lived when she saw another child shaking violently on the ground. Her husband insisted that the watchman go with him to bring the doctor to the clinic, while Binta helped the young mother with her convulsing child.

Aminata Touré had always been bright and curious, even in her village school where only a few young girls sat among the farmers' sons. Over the years she had remained near the top of all students in her classes. She particularly enjoyed biology at the prestigious Catholic high school in Kouroussa, where she was a boarder. At the *lycée*, she decided to train as a nurse after graduation, instead of joining the convent. She had finished nursing and midwifery school just two years before, and was assigned after graduation to Yalosemba to work with Moussa Barry, an elderly male nurse who had remained in small towns throughout his career.

Moussa told Aminata that he loved the rural environment where he could care for *les pauvres*, as he called them with gruff affection. In the bush he could also tend to the small farm that the community provided to him, as a necessary supplement to his modest government stipend. The villagers loved Moussa, and they would resist loudly whenever there was a rumour that he was being transferred to a larger city. So he had stayed in Yalosemba for the last 12 years, with his two wives and 10 children. Moussa was generally forgotten by those in the capital, several hundred km distant. Aminata also was captured by the rural setting. She especially enjoyed her work with the young women, who had little information on becoming (or not becoming) mothers and on caring for healthy children.

Two days earlier, Moussa had gone to the district headquarters in Bouaflé to get medicines. The resupply was two months overdue, as usual, and the heavy rains had begun three months ago. The number of patients with *eba* was increasing, as was the occurrence of anaemia. Moussa had noted since April that the women were delivering smaller babies, and more infants were dying, particularly in the month following birth. Most perplexing of all, the drugs for fever were not only in short supply, but they also did not seem to be as effective as they had been in previous years. The fever remained longer, and many children did not respond at all to the drugs. Moussa pondered these things as he bicycled to the district headquarters at Bouaflé, a two-day effort. He had much to discuss with the public health physician, who had not been to the Yalosemba clinic for eight months.

It was early in the morning when Aminata heard the commotion outside the house as her cook explained to the father and the guard that the 'doctor' was not yet awake. She dressed and came to the front door rapidly when she heard that a child was having convulsions on the dirt assembly area in front of the clinic. It was unusual to be called like this, except for an obstetrical emergency, or for a severe injury inflicted by an animal or a tool — rarely for a sick child. Aminata understood the insistence of the man at the door; she thought it was important that parents fought for their children's lives. To accept fate was the old way. Aminata had seen her sister die in childbirth while waiting for the *guérisseur's* herbal concoctions to work in a rural hut, eight years ago. She also knew that children were often found lifeless under their thin coverings when she and Moussa arrived under the baobab tree each morning to screen the patients. Aminata and the two men hastened down the road to the clinic as the fog began to rise off the ground in Yalosemba.

The child with convulsions was dead when they arrived, her mouth filled with vomit,

the inner lining of her eyelids as pale as cotton, a clear sign of anaemia. A quiet exchange with the mother indicated the same monotonous history as recounted by so many other young mothers — a one-year-old child, breastfeeding and in apparent good health — then abruptly, fever for three days, rapid breathing two days, little to eat or drink, one tablet of fever medicine given the night before last, advice and potions ministered by the traditional healer, coma, convulsion, death.

The girl's mother was in her late teens and was weeping quietly, awash with anguish and helplessness. Several women came to her, offering solace and strength. Each had endured the same event in their own families, yet none had ever been able to understand why the children died, or to divine meaning from this catastrophe. Each woman could commiserate with the young mother, but they could not change the way things happened in their villages, or even in the Yalosemba clinic. This was death's way in Africa.... Mamadou's parents observed the tragedy. They did not accept this way. Mamadou would survive, as Oumar had survived.

Aminata walked around the courtyard in the dawn light, quickly assessing the condition of the 50 or so patients. She gave each a number based on the severity of their illness. Several were gravely ill, more so than usual. She knew many families had walked long distances. Perhaps, despite the tradition of resignation in the face of sickness, they sensed that the event they had just witnessed was preventable. As the morning progressed, Aminata was struck by the observation that few fathers accompanied their sick children to the clinic. The exception was Mamadou's father who, after feeding his son, was helping to nourish several other children whose mothers had gone to search for the medicines that she had prescribed, the clinic being out of the most frequently used stocks.

Aminata finally saw Mamadou, carried in his father's arms. The boy was very weak, pale, dehydrated and feverish. Malaria! This scene had become too familiar. Aminata knew that malaria would weaken a child quickly, and coma might be imminent. Fortunately, the boy could still swallow medicines, but not easily. Unfortunately, the medicines she knew he needed were not at the clinic.

She also knew better than to think that Moussa would return with the medicines faster than the four to six days of haranguing needed in Bouaflé to secure supplies. Mamadou was admitted to the hospital, and a prescription was given to the parents for antimalarial drugs. She deferred giving a blood transfusion because an examination of his conjunctivas and his palms showed that the haemoglobin did not appear to be disastrously low; his acute problem did not seem tied to anaemia — not yet. If the drugs were not available at the pharmacy, she would advise that they go to Bouaflé, the regional capital, but Aminata knew that the time and expense made this long trip improbable for most. Without medicines for this child, the consequences would be...predictable. Aminata called the number for the next patient to come in.

While the father went into town to fill the prescription, Binta carried Mamadou to the small in-patient section of the clinic. It had 25 beds, all filled, some with two or more children in a bed. A nursing aide took the child's temperature, weighed him, recorded the information and hung the clinical chart on the frame at the foot of the battered metal bed.

The aide told Binta that the treatment for malaria would begin when the drugs arrived with her husband. She directed Binta to the communal kitchen in the middle of the courtyard, and told her to pay the 1,000 CFA francs (US$3.70) for hospitalization at the cashier's office. This amount of money represented several days of work in the fields for her husband.

Binta surveyed the ward as she walked Mamadou to his bed. She remembered the excitement in the community 12 years earlier, when the clinic was being built and when Moussa, the first nurse, came to serve. Binta recalled her anxiety and joy when Oumar and then Mamadou were born here, in the maternity clinic. She recalled the protestations of her mother-in-law, who wanted a traditional birth in the hut of her husband's grandmother. Binta sighed deeply as the image of her own aunt's quiet death from haemorrhage during childbirth in her grandmother's hut flashed into memory. She pulled Mamadou closer, and felt his heat, sweat and shivering as if they came from her own body.

The children were very sick in this ward, a few had intravenous tubes running into their scalps, several were breathing rapidly, a number had bloated abdomens and spindly extremities — others bore disturbing skin rashes. Two were comatose. On the floor near each bed sat one or two women, each with a few cups, metal pans and bowls, some liquids in different types of bottles, a few medicines.

When Aminata came into the room, the conversations ceased. All eyes turned towards the nurse, asking silently in unison: "Will my child recover or die?" "What to do?" "What could be done?" The nurse, called 'doctor' in the morning when she came to the clinic, stopped by each child, felt the child's head or abdomen, and then washed her hands in the basin carried by an assistant. Afterwards she looked directly at each mother and told them the news, usually bad news tied to the late arrival or lack of medicines. In this way she was reassuring, unlike the health workers at the hospital in Bumba, closer than Bouaflé, but with a reputation for poor care. In Bumba, the staff would talk too much, avoid the eyes of the frightened family members and hasten out of the wards without touching or examining the young patients.

Mamadou shared a bed with a boy who had been admitted earlier that day. The boy was coughing, had sunken eyes and appeared poorly nourished. The boy's mother said that he had had diarrhoea and had been coughing for three months. Binta noted that the boy's mother also had a cough and appeared listless; she was spitting rust-coloured sputum into a rag at her side. Mamadou was frightened now, too weak to sit up alone to drink the water and gruel that Binta offered. Like concerned mothers everywhere, Binta thought that her son did not deserve this torture.

Kassamba found the small pharmacy at the centre of town, across from the market. The pharmacist looked at the list and said that the prescribed malaria drug was out of stock, but he had just received a new drug that was highly publicized as an excellent drug for *eba*. It was very expensive, over 50 times the cost of the other drug. The medicines for fever, pain, cough and convulsions were in stock. Kassamba gave the pharmacist all of his remaining money, 1,500 CFA francs (US$5.60), but with this he could only purchase half the needed supply of the medicines prescribed. He hastened back in the afternoon sun to the hospital, arriving just as Mamadou was beginning to convulse once again.

He found Aminata in the small laboratory and reported his son's condition. The nurse came immediately to the ward. They held the boy steady for a moment, until he relaxed. She put a tube through the child's nose into his stomach. Together they crushed one of the

newly purchased malaria tablets between two spoons, mixed the powder with water, and injected the mixture through the tube into Mamadou's stomach. Mamadou's hands and feet felt clammy, and he could not be roused.

Aminata noted this immediately and concluded that the child's blood sugar was low. She went to the small hospital pharmacy and found a vial labelled 'glucose', along with a sterile syringe and needle. When Aminata returned, the child's eyes were jerking upward towards the head of the bed, his arms were extended and his hands flexed to his sides. Cerebral malaria, she thought. She also knew that the child should have a spinal puncture to eliminate bacterial meningitis as a cause of this illness, but the needed materials to do the procedure properly and perform a staining test of the spinal fluid had not been available in the clinic for months. Aminata filled the syringe with glucose, had trouble finding the vein, but managed to inject most of the solution intravenously. It was unlikely that the child would survive without quinine, she thought, and the quinine would be available only when Moussa returned.

Mamadou's eyes slowly moved downward and he slept. Tears were rolling down Binta's cheek as she stood helpless at the foot of the bed holding her son's ankles to prevent an injury. The nurse touched the mother's arm lightly, caught her painful gaze, and urged Binta to rest while the medicines began their battle. Another child in the room began to convulse. Aminata moved towards her.

Obtaining essential drugs in Bouaflé

It was afternoon in Bouaflé, and Moussa was shouting — something that the people of Yalosemba would have been surprised to hear from their 'doctor'. For two days he had painstakingly gone from office to office to obtain the appropriate signatures needed to release the stock of medicines due at the clinic two months ago. At each office he waited patiently for the bureaucrat to arrive, often in late morning or afternoon, if at all. Twice he went directly to the homes of ministry officials when they didn't show up at their offices. Fortunately, the Minister of Health's mother-in-law had come from Yalosemba, and he used her name several times to obtain the signatures.

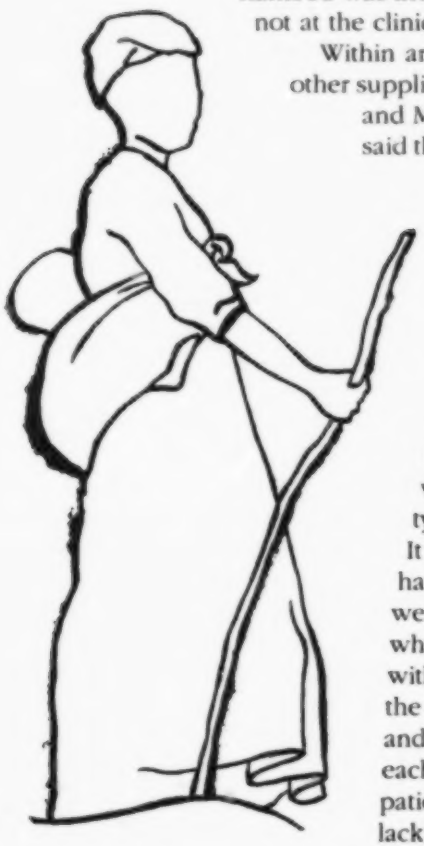
However, it was now 2 p.m. on Friday afternoon, and he was at the drug shipment section of the Central Pharmacy depot. The chief of the shipment section and his deputy were gone. Only a secretary was present, and she wouldn't tell Moussa where they were. Moussa suspected that the all of the Central Pharmacy directors were attending a political meeting, and probably would not return until Monday or Tuesday. It didn't take Moussa long to discover the location of the meeting. He asked the secretary to type out the names of the Minister of Health and his wife and mother-in-law on a sheet of official stationary. Underneath these names he had the secretary type the sentence: "See attached list of supplies and take action urgently." An official seal was affixed to the note with one of the many rubber stamps on the secretary's desk. Moussa knew that people responded more to the look of authority than to the real thing. He folded the packet into an official envelope and bicycled to the political meeting.

Moussa found Mr. Kambou, the Director of the pharmacy, outside the political party meeting hall just before the afternoon speeches began. The Director had been recently assigned to Bouaflé, and the only name he recognized on the cover paper that Moussa gave

him was that of the Minister. Kambou was young, having graduated from the National School of Pharmacy only five years previously; however, he was already sensitive to the many devious techniques used to steal or release medicines illegally from the pharmacy stocks. But he was serious about his job, and quickly understood the needs in Yalosemba. He was genuinely dismayed that there had been no delivery of medicines for two months at the rural clinic.

After noting that Moussa had obtained the approvals for receiving the clinic stocks, Kambou hesitated before entering the hall. Thus far the day had been absolutely wasted with speeches and promissory notes about future programmes for the rural poor. Not one person had addressed the failure of the current projects and programmes.

The Director pulled the Chief of Shipments out of the meeting and asked Moussa to join him at the pharmacy. Then they went immediately to the warehouse. The inventory clerk was called, and together they started collecting the medicines on the list. Kambou was irritated that some drugs were in ample supply at the pharmacy and not at the clinics; other critical drugs were missing at both places.



Within an hour, Moussa had assembled three large cartons of drugs and other supplies. The Director asked how the cartons were to get to Yalosemba, and Moussa said he usually brought them back by bush taxi. Kambou said that he was planning to visit the local clinics soon, and he might as well begin this weekend.

The medicines were put in the back of the pharmacy truck, along with Moussa's bicycle, and covered by a tarpaulin. While driving to the Governor's home to inform him where he would be spending the weekend, Kambou pondered the number of clinics like Yalosemba that were lacking stocks of drugs for malaria and other diseases. As they left Bouaflé at dusk, they could see lightning crackling above the road. The rains began lashing the truck only a few kilometres outside the city, and in a half hour they left the paved road. The Director shifted to four-wheel drive when the truck started skidding into the fields and the tyres began to sink deeper into the quagmire.

It was about midnight when they arrived at Yalosemba. They had had to dig out of the mud three times within 15 km of the town and were soaked. Aminata came out, elated when she found who and what had arrived. She prepared some soup and peanut sauce to go with the rice left from the evening meal. Aminata recounted to Moussa the difficult medical problems she had seen since he had left. Moussa and Kambou marvelled at the perceptiveness of the young nurse. For each patient, her reasoning and action seemed sound. But for each patient the limiting element was the delayed diagnosis and treatment, lack of drugs, and the confused role of the family members in the healing process.

Aminata mentioned the three young patients with a severe malarial infection who needed quinine. They went to the hospital and unloaded the cartons in the downpour. In the small pharmacy, by kerosene lamp, the group dug through the medicines. They found

the quinine vials, intravenous tubing, alcohol, roll of cotton and tape.

Binta and Kassamba awoke from their vigil on the floor as the medical team came into the darkened ward. Mamadou had stopped convulsing in the late afternoon and had been breathing rapidly, without responding to their voices or touch, since early afternoon. His body was still very warm. As Aminata held the lamp over the child, others began to stir on the floor. Moussa had momentary trouble finding a vein to receive the needle, but within a few minutes the intravenous fluid was coursing into the child's arm, each drop containing quinine, the best drug for this type of malaria. They found the other two seriously ill children and repeated the process. One of them had pneumonia and required an antibiotic. Fortunately, the load of medicines they had brought from Bouaflé contained antibiotics. The other patients in the hospital were resting quietly, except for the boy next to Mamadou who continued to cough.

It was early Saturday morning in Yalosemba when the medical team went to their beds. Kambou tucked the protective mosquito netting under the mattress as he collected his thoughts from the troubling events of the day and night. Rainwater drummed down on the corrugated tin roof and raced along the undulating gutters, pouring into the 200-litre gasoline drums used as water-collecting barrels. Pools of water covered the compound grounds. The din was such that the buzzing sound of the thirsty female mosquitoes could not be heard.

The crowing of cocks and the fresh aroma of coffee greeted the Director's senses as first light splashed on Yalosemba. Pleasantly disoriented in the comfort of the rural environment, he stiffened and rose when he heard alarm in the voice of Kassamba at the door, not far from the bedroom. A child at the hospital was gasping for breath. The nursing aide did not want to disturb the 'doctors', but Kassamba insisted that help was needed immediately, and they should inform the doctors as they had done the day before. The gasping child, breastfeeding last night, could not be aroused.

This child was one who had been given chloroquine syrup and an aspirin tablet the previous day for fever. Both medicines had been bought from one of the many market women who sold a few drugs along with cigarettes, flashlight batteries, sugar and cola nuts. Moussa had just come from his nearby house and, as Aminata and Kambou gulped down their coffee, he reassured Mamadou's father that they would be at the clinic within a few minutes.

The three health workers hastened towards the hospital as Aminata recounted her observation that the usual medicine for malaria, chloroquine, did not seem to be working, and that the syndrome of fever, convulsions and anaemia was becoming the most common reason for admitting children. This ominous triad would occur a day to a week or two after a mildly ill young child would come to the clinic with fever and be given a prescription for chloroquine. Because the drug was not available at the health unit, the chloroquine syrup would be purchased from a market vendor.

Moussa again wondered about the diminishing effectiveness of chloroquine, but had received no information on possible drug resistance in this area of the country from his supervisors or from workers attached to the state malaria programme. The Director thought about those drugs on the open market, their misuse, their possible lack of potency and the increasing problem of illicitly manufactured worthless products.

A small, 18-month-old girl was lying in the darkest corner of the ward, gasping for air

in her mother's lap. The child's chest muscles were labouring, and her nostrils flared with each breath. Another child, the girl's twin brother, Sekou, was lying on the cot. They were both very hot to the touch. The children's mother was no more than 16 years old. She looked very frightened, and was deferring to her grandmother, who was rocking back and forth chanting the song of grief for children. Grandmother was an expert.

Moussa felt the belly of the child in the bed, confirmed the enlarged spleen, looked at his watch, and noted that the child took a breath every two seconds and did not have laboured breathing. He was relieved that Sekou probably did not have pneumonia. However, his temperature at 6 a.m. was 42 degrees Centigrade. Moussa knew that this was not the child whom he had been called so urgently to see, but he also knew that Sekou had a chance of surviving, while his twin probably did not.

Aminata came with the blood smear material, the haemoglobinometer to check for anaemia, the glucosometer to measure the blood sugar, the intravenous bottle and tubing, disposable syringes and needles, and the medicines, none of which had been available for use in the clinic the day or even the month previously. Moussa explained to the mother and her grandmother that both children had severe malaria and that the girl also had pneumonia. He would take a few blood samples, and would begin to administer the medicines directly into the child's bloodstream.

Then, the hard explanation began, one he seemed to give to family members about once a month, and about once a week during the rainy season. Treatment would begin with Sekou because his chance of survival was greater, but he would treat the sister afterwards; he did not discuss the shortage of medicines with the families. Aminata had completed taking specimens from Sekou. The blood sugar was low, but the haemoglobin level indicated that, for now, a transfusion was not to be given.

The laboratory technician in Yalosemba had been taught by Aminata to type blood, but they could not yet check for the AIDS virus in Yalosemba. AIDS was becoming more of a problem in their community, as infected persons from the capital and larger towns returned for festivals, vacations and cures from the *guérisseurs*; during these visits they would unknowingly seed the rural areas with the deadly virus.

Moussa carefully cleaned the child's arm with alcohol and cotton and, more by feel than sight, found the thin strand of a vein in the crease of the elbow. He plunged the thin needle into the vein and, as the crimson liquid poured out, he slipped the end of the tubing into the needle. Moussa taped the needle to the boy's arm securely and placed a small slat on the back of the arm, assuring that the elbow would not bend, thus displacing the needle. He rolled back the control wheel on the tubing, and the cadence of the drip increased smoothly.

Aminata told him that the blood sugar level was very low, as she had anticipated. She then prepared a syringe filled with glucose. Moussa verified the child's weight on the clinical record and injected the solution slowly into the tubing. He then measured out the proper amount of quinine into another syringe and injected this into the bottle of solution that would be given over a four-hour period.

Moussa looked over and saw Aminata leaving the room hastily with the young mother and the twin infant who had been gasping when they arrived. As the mother placed her small daughter on the examining table in the treatment room, Moussa saw that the child was limp and had stopped breathing. While he was consoling the mother, the child's great-grandmother came through the door, wailing for them all.

Moussa glanced at his hands and saw that they were covered with blood from the effort to insert the intravenous tube. As he went to the basin at the sink to wash, he remembered that rubber gloves were in short supply in Bouaflé. He had been unable to obtain any for the clinic. So, with neither gloves nor condoms Moussa wondered how he was going to protect his hospital staff and the community members against AIDS.

Moussa began his morning visits. All eyes in the ward were riveted on him as he went from bed to bed. When he came to Mamadou, Moussa recognized the boy's father as the one who had come for him when the young twin girl was found to be near death. This parental insistence was uncommon, thought Moussa, but commendable. Mamadou's condition had improved, even a few hours after the quinine infusion had been started. A remarkable drug, thought Moussa. The other child whom he had seen a few hours before was also stable, but, unlike Mamadou, was now able to follow Moussa with his eyes as he walked around the bed.

Moussa told the aide to take the coughing child sharing Mamadou's bed and place him and his mother in a separate room until several of their sputum specimens could be examined for tuberculosis. Moussa had found the needed stains to do this in Bouaflé. Moussa was aware that tuberculosis was becoming more of a problem, particularly when AIDS had affected the patient. Yet, without the proper material, how could either of these diseases be diagnosed?

In the laboratory, Aminata was looking through a microscope at a blood slide which, laden with very pale red blood cells, had been taken from Sekou. Moussa could see that several of the cells contained blue oval parasites with their purple jewel of a nucleus — the 'signet ring' appearance of *Plasmodium falciparum*. Malaria, he thought, lovely and deadly. Some cells had two parasites. One in five blood cells had one or more 'signet rings'. The outlook was grim for Sekou, even with the quinine.

Kambou walked into the laboratory after having reviewed the records and stocks of materials at the clinic pharmacy. He told Moussa and Aminata that he was astounded to find how often the clinic had endured a rupture of supplies, particularly during the past two years. Several of the drugs on the shelves were outdated, of questionable effectiveness and costly. Although patients paid something for their hospitalization, they did not have to pay for drugs. The list of essential drugs — those 200 or so effective and affordable medicines — had not yet been distributed to the staff at Yalosemba, despite having been approved two years earlier by the Council of Ministers in the capital. Antimalarial drugs were constantly in short supply. Kambou asked Moussa and Aminata to accompany him to the market to look at the products sold by the *vendeuses*, the ubiquitous women merchants.

The next day, Sekou's conditioned worsened; his temperature was decreasing but he was becoming more lethargic. The infusion of quinine continued. Now, Mamadou began to respond to his parents' touch and he began to open his eyes, but he still could not hear well when Binta spoke to him. Shortly thereafter, Mamadou began to eat and drink, but needed support from his parents as his arms and legs remained quite weak. However, the

boy stared straight ahead, unable to follow movement; he didn't flinch when Moussa's open hand was rapidly brought in front of his eyes. The day after awakening from the coma, Mamadou could hold a cup independently using his right hand, and the intravenous tube was removed from his arm. Aminata was relieved when she found that parasites were gone from his blood three days after his arrival at the hospital.

Mamadou could talk, but Binta noted that he was different, slower, quite weak in his left hand. And blind. Five days after coming to the hospital Mamadou could hear better than when he awoke from the coma. Two days later he was discharged after completing the quinine treatment.

Aminata told his parents to protect him against mosquito bites by having him sleep under a bed net in the bed he shared with Oumar. That they could do, but the cost was 5,000 CFA francs (US$18.60), beyond their means for another several months, and the nets were available only in the markets in Bumba or Bouaflé.

Aminata was not entirely sure what response to give when Mamadou's father asked what they should do if Mamadou or Oumar became feverish again. She said to give them chloroquine tablets at home and, if they didn't improve within two or three days, to return to Yalosemba. But Mamadou's parents had heard the doctors murmuring that chloroquine was no longer effective in their area. The alternate drug, called Fansidar, was not readily available, and was more expensive than chloroquine. The father said that he would try to buy both drugs and keep them at home for the fevers.

Binta and Kassamba knew that the fevers would be returning to their family, as they always returned every month or two to each family in their village. And Binta would be having another child next year. The family members went to the father's family compound in Yalosemba to continue Mamadou's recovery, and remained there another week.

Samples from the market

Just before Mamadou left the hospital, Kambou returned to Bouaflé with several samples of drugs collected in the market. He suspected that some of the materials in the bottles and packets might not be potent, or worse, could contain dangerous products; Kambou explained to Moussa and Aminata that sham drugs were becoming a frequent problem throughout the country, and that the unsuspecting rural populations could suffer most from this scandal. The night before the pharmacist's departure, Sekou died quietly in the darkest corner of the hospital, in the same arms that had cradled his sister to her death, and accompanied by the same mournful wail of his great-grandmother.

After two weeks, Mamadou's appetite had increased, and he began to distinguish distant objects, but with difficulty. The family returned to the village over the muddy, humid trail. There was happiness and excitement when relatives and neighbours saw that Mamadou was more energetic than when he had left. For a few days the boy sat in the compound, regaining his strength with the *tob* and special sauces prepared by Binta, fortified with chunks of fish and meat that were usually reserved for the grown men. His friends came to greet him, but Mamadou could not see their faces as clearly as before the onset of illness. He had even forgotten the names of two of the boys who were his closest friends.

While playing on the village soccer field two weeks later, Oumar kicked the ball over

the heads of several scrambling barefooted children towards Mamadou, who was standing on the sidelines. Oumar was the first to notice that his brother was not able to track the sphere of rags as it arched across the dusty terrain and smacked against Mamadou's limp left arm.

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Over the 12 months following Mamadou's return home, it became clear that he would never enter school with his peers, represent his village in the county soccer championships or plough the fields in preparation for the planting of millet, corn or cotton. Mamadou's parents began his rehabilitation with the assistance of a retired schoolteacher who had been enlisted by the village women's committee to teach the preschool children. Despite their sadness at Mamadou's partial blindness and paralysis, Kassamba and Binta became more resolute in wanting to prevent a repetition of their son's illness, and those of other children whom they had seen at the Yalosemba hospital. What could be done?

At a meeting of the village elders, Kassamba heard about the recent formation of a village health committee. There was much talk about building a dispensary in the village and getting a government nurse to staff it. Yet the topic that interested Kassamba most was a presentation by a young woman from the public health office in the regional capital on how the community could purchase and maintain a supply of commonly used drugs, including antimalarial drugs. Each one at the meeting had had a son or daughter severely ill with malaria, pneumonia or measles — or all three.

Kassamba and Binta joined the management section of the health committee. Kassamba was elected president, and Thérèse Traoré, the president of the women's group, became the treasurer. Over the next two months, many families contributed money to buy an adequate supply of the 10 to 15 drugs that were on the list of essential drugs for village health workers. However, only about half of the families joined the health scheme and paid their fees.

One day, the committee was addressed by a special guest — Moussa Barry, who came and talked to all residents about choosing their own health worker. He talked about the responsibilities of the volunteer worker, the family members and the village. He discussed the signs and symptoms of common illnesses, and the importance of seeking medical help early for potentially fatal diseases. Malaria was mentioned first, and Binta saw tears in Kassamba's eyes when Moussa talked about the complications that could occur if this terrible disease was not treated promptly. Moussa also announced that a new item was being

added to the essential drugs list — special mosquito nets to protect against malaria. Right after his visit, the health committee went from house to house to explain the village 'Santé pour tous' plan, and to encourage more families to support the drug supply fund. The household visits by respected community members boosted membership in the fund to almost 80 per cent. Several very poor families, many without a resident father, or belonging to an ethnic minority, were identified and targeted for special membership assistance. They would try to repay their share of dues at the end of the harvest.

On the recommendation of the health committee, Dembelé Keita was chosen as the health volunteer at a well-attended meeting of the village council. He was literate, young, energetic and had worked with the agriculture extension agent in explaining new irrigation methods to the local farmers. Dembelé had inherited a small plot of land from his father, and the village council voted to give him another piece of land as a bonus for being the health volunteer. Dembelé then spent three weeks in Bouaflé, where he received training in basic first aid and in management of the drug supply materials.

Over the following months, Thérèse and Kassamba would meet with Dembelé weekly, assist in reviewing his records, count the tablets remaining in the kit, prepare orders for supplies, calculate the money collected and order replacement drugs. They also heard wonderful stories from the population of the fine work that Dembelé was doing, and of his availability at night and on weekends. Each month, either Moussa or Aminata would come to the village to see the patients with special problems such as leprosy, slowly healing wounds or chronic cough, and to publicize vaccination, protection from mosquito bites, clean water, antenatal care, family planning and other subjects dealing with prevention.

A special celebration was held when the Pharmacy Director from Bouaflé, Mr. Kambou, joined Moussa in one of the monthly visits to the village. The Director recognized Mamadou and his parents. He informed Binta and Kassamba that the establishment of health committees in villages was becoming very popular throughout the country. Kambou had brought a fresh supply of mosquito nets with him. He was delighted at the large group of people present when he and Moussa gave a demonstration of how to soak the nets in insecticide and install them in their homes. After the demonstration, the entire village broke into approving laughter when the first person to jump up and offer to buy a net immediately was Sidimé, man of powders, herbs and small skulls.

Table 1. Health care expenditures: What people pay vs. what governments spend

In countries where public sector health care is ineffective, poor or non-existent, people are forced to pay for alternative services. Consistently, people often pay much more for health care from their own pockets than the amount that their governments contribute to the public health care system.

Country	US$ annually per person	
	What people pay	What governments pay
Sierra Leone	14	3.25
Mali	5.62	1.8
Benin	5.24	2.86
Rwanda	3.28	1.88
Nepal	2.96	1.98

Sources: UNICEF, World Bank, others, 1988-1990.

Table 2. Reasons why people do not seek medical treatment (Sierra Leone, 1990)

There are various reasons why people in the developing world do not seek treatment when they are ill, and these vary according to the seasons. A survey among villagers in two districts in Sierra Leone shows that between 5.7% and 8.1% of households chose not to have any kind of treatment for sick family members. The reasons are tabulated below, and they indicate, in percentages and number of episodes, that the availability of money may be more important than any other factors.

Main reason	Dry season		Rainy season	
	Percentage	Number of cases	Percentage	Number of cases
Thought not serious or recovered soon	11.9	32	26.7	58
Too far or no transport	2.6	7	4.1	9
Not enough money	54.3	146	37.8	82
Dislikes dispenser or nurse	2.2	6	2.8	6
Thought drugs unavailable	2.2	6	1.4	3
Thought medical treatment ineffective	5.2	14	9.2	20
Knew self-treatment	14.9	40	12.4	27
Other, unknown or missing	6.7	18	6.6	12
TOTAL	100	269	100	217

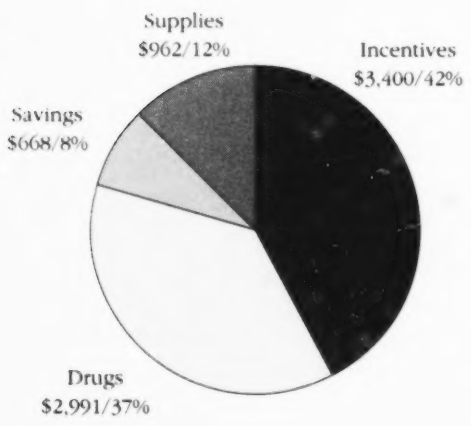
Source: Fabricant and Kamara, 1991 (Bamako Initiative Technical Report Series, no. 9).

Table 3. The community takes charge of health centre funds

With communities taking over the management of funds derived largely from sale of health services, operations have shown definite savings. The following pie charts also show the proportion of funds going to purchase of drugs and all other supplies, incentives to staff and the costs of operating the health facility.

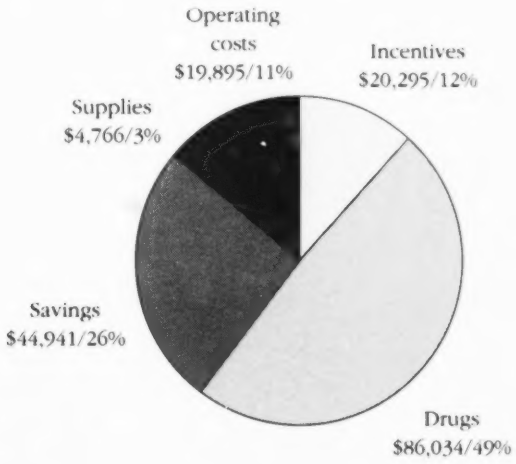
NIGERIA

6 centres, covering population of 317,320 (9 months)



GUINEA

86 centres, covering population of 1,223,662 (6 months)



* Percentages do not add up to 100 because of rounding.

Source: In-country data collection (Ministries of Health/UNICEF), 1990/1991.

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